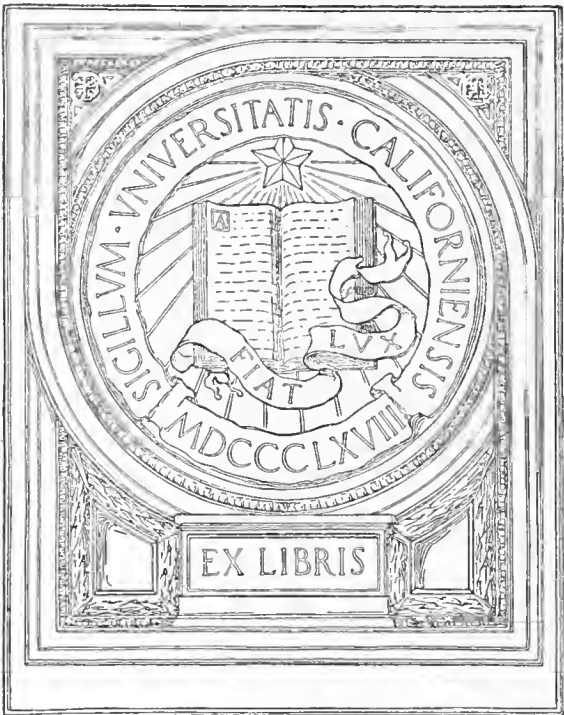



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The JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Vol. XLVI

FORT SMITH, ARKANSAS, JUNE, 1949

No. 1

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PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
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*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.





EUCLID M. SMITH, M. D.
Hot Springs National Park
PRESIDENT
Arkansas Medical Society
1949-1950

The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. XLVI

FORT SMITH, ARKANSAS, JUNE, 1949

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PRESIDENT'S ADDRESS

P. W. LUTTERLOH, M. D.

Jonesboro

All living organisms, whether animate or inanimate, depend for their life and development on their environment. The plant draws its sustenance from the soil in which it is rooted. If the soil provides moisture, air and the food elements of the kind needed by the plant, and, if the texture of the soil makes all these available to the plant, the plant will grow and flourish.

The same law applies to the child. It, too, depends upon its environment not only for food and shelter and clothing, but for those intangibles, which, for lack of a better name, are classified as spiritual. The prevailing ethical standards of his environment have much to do in shaping his moral character. The intellectual atmosphere of his surroundings conditions his development.

But it is no one-way street we are considering. The environment can be changed, not only by forces operating from the outside but from the inside as well. The upward reach of society is a record of man's impact on environment. He tunnels mountains, bridges streams, modifies climate, makes the desert bloom, conquers disease, annihilates distance, makes the laws of nature do his will. Trees and plants gather plant food from the air and transfer it to the soil, thus enriching it for the use of later trees and plants. Even the earthworm in the ground cultivates the soil by opening to let in air and water. Nor may we omit the work of certain forms of rock, which, by their disintegration improve the soil. The great corn and wheat states of the Middle West owe their fertility to the disintegration of limestone brought down from the north by the glaciers of a former age.

Having discussed at some length the mutual relationships of plants and animals to their environment, let me now come directly to the subject of my paper—THE RELATION OF THE DOCTOR TO HIS PUBLIC.

No sooner have we even glanced at the subject than we are impressed by the fact that much, if not all, we have said applies to the

specific application of the general principles indicated above. But, first, what IS the doctor's public?

John Wesley, founder of Methodism, in indicating his environment or public as a teacher, said, "The world is my parish." By that he meant that every human being was actually or potentially a sheep of his flock. Neither race nor creed, habitation or status, was outside his field of activity. He was interested in every one in the world. In taking this stand he was best following the Great Teacher who had the same views and convictions. In answering the question, "Who is my neighbor," he did not exclude the Samaritan, the man who was listed as an outcast by the more fortunate members of society—the man who could not repay even the slightest service rendered him. Can the doctor be less generous in his attitude than this despised Samaritan?

No one knows better than the doctor how difficult it is to disregard racial, financial and cultural lines in outlining his sphere of activity—his public. Some people are more agreeable patients than others, some pay better, some organize themselves around the doctor and practically control who may and who may not be his patients. A new doctor comes to the community. If certain families call him in, other families in the same social class will do likewise. Soon he has a select group upon whom he may depend to maintain his practice and guarantee his prestige. He may soon come to feel independent of the less favored class and act accordingly. It may be that he still holds membership in the Rotary Club but he no longer acts on the principle of "Service Above Self."

I am keenly aware that in bringing these questions up, I am treading on dangerous ground. Doctors set great store by tradition, especially by the traditions of their profession. So firmly do they stand by these traditions that they may at some time find themselves adhering to these traditions even to the point of ignoring their ethical code. I leave the decision to the conscience of the doctors themselves.

Up to this point I have confined myself to

what may be termed the strictly professional aspect of the question. Now I wish to discuss the questions rather from the human than the professional point of view.

For the doctor is first a man, then a doctor. He has all the duties and obligations of other men. In fact, he has more than most men, even public men. The fact that he goes into the homes of people in a way scarcely less intimate than that of the preacher marks him as almost a member of the family. To him the family looks for help in combatting disease and in repairing the damage done by accident. He is a trusted friend and counsellor. He shares many, if not most, of their secrets. He knows their anxieties, their ambitions, their secret hopes. To be worthy of this confidence and veneration the doctor must meet his public more than halfway. He must identify himself with all movements and agencies that have for their end the betterment of conditions in the community. He should be active in his church. He should take a personal interest in the school. He should be ready at all times to lend a hand when constructive work is needed in the community. And at all times his attitude toward movements for civic betterment should be such as to inspire confidence in him as a leader.

Nor does his duty end here. There is a personal relationship which has nothing to do with professional duties. Young people should feel that in their doctor they have a friend who understands and is willing to enter into their problems and help in every way he can.

To be THE FAMILY DOCTOR is a rare privilege and a challenge.

I am assuming that if the doctor is all that he should be and does all he can along the lines indicated, the public, at least his public, will react properly and give him their intelligent and whole-hearted support. Exceptions there may be. But by and large he will find ample support and sympathy adequate to his needs.

Organized medicine is just beginning to wake up to the average patient's problem of meeting the rising cost of medical care and to do something about it.

Federal Security Administrator Ewing, regarded as the chief propagandist for compulsory health insurance, or, socialized medicine, demands more doctors, more hospitals. We are of the same opinion. He wants an increased number of patients to get better care. We, too, are anxious for that. What are the best means to secure these ends?

The medical profession is already supporting

a voluminous medical service insurance plan—The Blue Cross-Blue Shield—and while right now dealing with groups only, it hopes soon to cover individuals as well. Other insurance companies are also participating in an individual and group surgical-medical and hospital plan. As a result, the above goes a long way towards covering defects, if any, existing at the present time. Medical centers are being set up and other problems are being worked out which seem to me to span the distance between what the medical profession desires and the demands of the public.

To put into effect immediately such a sweeping compulsory set-up as advocated by Ewing, would result in poorer surgical and medical care. This could only mean the throttling of the medical sciences in their rapid advances toward control of heart disease, cancer, tuberculosis and other much dreaded diseases.

The over-all resultant great increase in the number of patients, the paper work attached thereto, the too great scarcity of doctors, would be quite burdensome to the medical men to meet the demands. There are not enough hospital beds to care for the extended demand. The medical men, I believe, should have another year or two, for time to study this problem to arrive at a plan which might be suitable to meet the demands of the public. The medical profession, I believe, is endowed, not alone with its professional ability, but also with as much business ability equivalent to the best. We certainly do not need Ewing and his followers meddling in our affairs.

The press is responsible for a rumor to the effect that representatives from Great Britain are in the United States in the hopes of securing financial aid to underwrite socialized medicine in that country reputedly breaking down. It is more or less authoritatively rumored that socialized dentistry has already broken down. I give this to you for what it is, a rumor.

I would particularly like to express the Society's many heart-felt thanks to the General Assembly of the State of Arkansas for the resolution passed by them and sent to Federal Congress expressing their detestation and complete disapproval of any form of socialized medicine.

May I also take this opportunity of expressing to the entire membership of the Arkansas Medical Society my sincere thanks for its whole-hearted support during my tenure in office. Too, I wish to offer my services to Dr. Euclid Smith, our incoming president, for any aid I may be able to give him during the coming year.

PREPAYMENT MEDICAL CARE

Report of the Council on Medical Service of the
American Medical Association, April 15, 1949

The rapid and orderly growth of voluntary prepayment medical and hospital care plans has been one of the striking and stimulating economic developments supported by American medicine during the past fifteen years. The initiating and propelling force of these plans was the medical profession acting through its local and state societies and later its national organization. This movement has attained national proportions. At the present time over 30,000,000 people are covered by Blue Cross type hospital insurance and over 10,000,000 by Blue Shield type medical care insurance. This stimulus and the accumulated experience gained by these organizations have prompted many private insurance companies to enter this field, and they are making substantial contributions toward the accomplishment of our ultimate objective, namely—voluntary health insurance at a nominal cost for all the people in the United States. The total number of persons covered by all voluntary agencies is 55,000,000 for hospitalization and 37,000,000 for surgical or medical care.

The American Medical Association is not engaged in the insurance business and has no intention of giving a preferential standing to any one type of voluntary plan. The American Medical Association does believe, however, that it has a definite function to perform, that of evaluating any insurance plan presented to the people, thus protecting them as far as possible against unscrupulous or unsound plans. The American Medical Association further believes that the people should be free to purchase the type of health security they desire. To this end the Council on Medical Service has for the past four years critically examined various plans and has given its approval to numerous plans operating on a local or state basis. The Council has felt the need for a national organization which would act as a trade and coordinating agency for all medically sponsored plans.

We therefore recommend:

- (1) The formation of a national coordinating agency representing all qualified voluntary prepayment plans in accordance with the proposal made to the Board of Trustees by the Council on Medical Service, February 10, 1949.
- (2) That there shall be no official connection between the American Medical Association and the Associated Medical Care Plans. However, the American Medical Association

will continue to approve or disapprove all voluntary medical care plans.

- (3) The recognition of AMCP as a trade organization of member plans and Blue Cross as occupying a similar position for voluntary prepayment hospital care plans.
- (4) The recognition of the responsibility of the American Medical Association to
 - (A) Promote the principle of voluntary insurance by educating the people as to their need for such coverage and by obtaining full cooperation from state and county medical organizations in the local field.
 - (B) Inform the American people of the availability of approved plans that propose to supply on a prepayment basis security against the economic hazards of serious illness.

OBITUARY

BRAXTON V. POWELL, aged 75, Camden physician and a past president of the Ouachita County Medical Society, died at a Camden hospital May 11th.

Dr. Powell had practiced medicine 52 years. Recently he was honored by the Arkansas Medical Society as one of the state's 50-year doctors still practicing. He served as a major in the Army Medical Corps in World War I, and was a reserve officer many years, formerly heading the Army Medical Examining Board in this area.

He was a member of the Camden hospital staff and had charge of its X-ray laboratory many years. He was a member of several veterans organizations, and an early Ouachita county family.

He is survived by his wife, three daughters and a sister.

A. C. SHIPP, age 70, died March 22nd at his home in Little Rock. Born in Edinburgh, Indiana, he graduated from Indiana University School of Medicine in 1912 and had lived in Little Rock since that time. He was four times president of the Arkansas Tuberculosis Association, had served as president of the Southern Tuberculosis Conference on two occasions and had been director of the National Tuberculosis Association from Arkansas since 1923. At the time of his death he was serving as chairman of the executive committee of the Arkansas Tuberculosis Association. In addition to his membership in the Pulaski County Medical Society and the Arkansas Medical Society, he was a fellow of

the American Medical Association. He had been a member of the Board of Stewards of the Winfield Methodist church for 35 years and had served that church as superintendent of the church school and as advisor to the young people's department. Surviving relatives are his wife, a daughter, and a son, Dr. Harvey Shipp of Little Rock.

RUFUS MARTIN, age 69, died at his home in Warren, April 15th. Born September 14, 1880, at Wheeler Springs, he attended Hineman University at Monticello and graduated from the University of Nashville Medical Department in 1907. He had practiced at Warren continuously since that date, serving in the army medical corps during World War I. He was a member of the Warren post, the American Legion, the Warren Rotary club, in which he had maintained a perfect attendance for nearly twenty years, and of the First Methodist church. He had served the Bradley County Medical Society as president for several terms. Surviving relatives are a brother and three sisters.

ALFRED F. GRAY, age 68 years, died of a heart attack at Little Rock April 22nd. A graduate of Memphis Hospital Medical College in 1908, he had recently opened a clinic at Little Rock with his son, H. F. Gray. He was a member of Hunter Memorial Methodist Church, Western Star Masonic Lodge, the Esther chapter of the Eastern Star, the Grotto and of the Pulaski County Medical Society and of the Arkansas Medical Society. In addition to his son, Dr. H. F. Gray, he is survived by his wife, another son and six daughters.

JAMES R. CRIGLER, Alma, age 73 years, died May 7th. Born in Charlottee, Arkansas, he graduated from Memphis Hospital Medical College in 1900 and first practiced in eastern Arkansas, moving to Alma in 1911. A 50-year Master Mason, he was also a member of the Van Buren Royal Arch chapter, Osiris Council, the other York rite bodies and he had held the degree of a Scottish Rite Mason for 46 years. He was a member of the Crawford County Medical Society, the Arkansas Medical Society, a Fellow of the American Medical Association and of the International College of Proctology. Surviving relatives are his wife, a daughter and a son, Dr. Ralph E. Crigler, Fort Smith.

DR. J. H. McCLEAN, aged 82, died at his home at Caddo Gap April 27th after a long

illness. Born in Mississippi, Dr. McLean was brought to Montgomery county as a child.

He was a practicing physician in Montgomery county for 47 years. He had taught school a few years before he began his practice. He was a charter member of the Methodist church, of which he was a member of the Board of Trustees. He was also a Mason. He had been secretary of the Montgomery County Medical Society for over forty years.

Survived by his wife, Katherine McGill McLean; two sons, Sage, a teacher at Magnolia A and M, and Dr. J. W. McLean of Greenville, S. C.; and two brothers.

"HOW THE WHITE HOUSE VIEWS IT"

April 11, 1949

Dear Doctor Oates:

The White House has asked us to answer your thoughtful letter about the proposed national health plan.

Although we are glad to have your views, we do not believe that the health proposals, when fully understood, can rightly be called socialized medicine. Socialized medicine or State medicine is a system wherein medical personnel work for the Government. Under national health insurance, the freedom of choice of doctor and patient is retained. National health insurance would be decentralized in operation. There would be a great deal of local responsibility.

I am sending you a copy of the Federal Security Administrator's recent report to the President, entitled THE NATION'S HEALTH — A TEN-YEAR PROGRAM, as I think you will be interested in having a comprehensive picture of the proposals.

Although this country has good medical care, the Administration's health plan would be a coordinated effort to improve the quality and make even better care available to more people. We appreciate the devotion to the service of humanity and the skill of so many in the medical profession. We look to the time when the great majority of people will be able to receive this type of care.

Thank you for having written.

Sincerely yours,

JOHN L. THURSTON

Assistant Administrator for Program

Gordon P. Oates, M. D.
Arkansas Baptist Hospital
Little Rock, Arkansas

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

EVERY argument used to encourage the examination of apparently healthy persons for the purpose of finding unsuspected tuberculosis gains added force when applied to college students. If tuberculosis is found among them in the early stage when it is more easily cured, future and potentially valuable citizens are saved for productive lives.

TUBERCULOSIS AMONG COLLEGE STUDENTS

Modern tuberculosis case-finding techniques applied to groups of apparently healthy people are productive of important, instructive and often startling results. Active and communicable cases of tuberculosis are not infrequently found where there is no other evidence that anything is amiss. Fortunately, the majority of cases so discovered are in an early or a minimal stage of the disease, when the chances for rapid, complete recovery are best.

To no other population group are the above statements of more importance than to college students. These young men and women are at the highest level of health, strength and vigor and from their ranks are recruited leaders for the various fields of human endeavor. From their ranks are also recruited many cases of tuberculosis.

For 17 years the Tuberculosis Committee of the American Student Health Association has been promoting interest in tuberculosis among the institutions of learning in the United States. For more than 10 of these years, all colleges have repeatedly been urged to develop a tuberculosis control program, and many have, although in some colleges tuberculosis still is not recognized as a serious threat to students.

The curve of college participation has shown an almost constant upward trend. For reasons that are not entirely clear, the 1947 returns show fewer programs reported. Each of the 885 institutions to which a questionnaire was sent was asked to return the questionnaire but only 311 replies were received, of which 259 reported a program.

In spite of lessened returns many cases of tuberculosis were discovered among college students. The total number of cases, presumably of the "reinfection" type, reported for 1946-47

was 630, and all but nine were found at colleges having anti-tuberculosis programs. In 1946-47, 590 arrested cases of tuberculosis were again permitted to resume their college work. They emphasize the fact that "they do come back."

Programs Employing the Tuberculin Test and

X-ray of Reactors

Colleges depending primarily upon the tuberculin test as their initial screening method numbered 105. Based on adequacy of data submitted, apparent proportion of student body tested and number of reactors X-rayed, 24 programs were roughly classified as "excellent," 34 as "good," 33 as "fair" and 14 as "poor." A college has an "excellent" program when entering students are tuberculin tested and reactors among them X-rayed, and when, each year, upper classmen non-reactors are retested and reactors re-X-rayed.

In recent years an increasing number of colleges have reported the use of both the tuberculin test and the chest X-ray for all entering students. It is recommended that this combined procedure be employed wherever facilities permit.

For better results, and to insure greater uniformity, tuberculin testing should be done intradermally (Mantoux), using Purified Protein Derivative of tuberculin P.P.D.) in two strengths. The first dose, prepared according to directions, is 0.00002 milligrams. If no reaction occurs after 72 hours a second dose of 0.005 milligrams is given. Equally dependable results may be obtained if Old Tuberculin (O.T.) is used. The first dose, injected intradermally, is 0.1 milligram. When no reaction occurs after 72 hours a second dose of 1.0 milligram is given. Failure to react to the second dose of either P.P.D. or O.T. may be

taken as evidence of freedom from tuberculous infection.

Programs Using X-ray Alone as a Screen

The main criterion for an excellent program was that all students were X-rayed annually. When this is done, most of the significant cases of tuberculosis will be found in a relatively short time.

Forty-seven colleges, distributed over 23 states, indicated that part or all of their X-ray program had been conducted by either the local tuberculosis association or one of the official health departments. One of the limitations of the X-ray is that it gives no certain proof either of tuberculous infection or tuberculous disease. Diagnosis may be made only after careful clinical study of a suspected case. Calcifications noted on chest films are not proof of previous tuberculous infection. Diagnoses have undoubtedly been ascribed to "healed childhood tuberculosis" when the true cause was *Histoplasma capsulatum*. One who reacts to tuberculin should have regular examinations, including chest X-ray, for evidence of active tuberculosis. Conversely, except in a few well-recognized instances, the non-reactor does not have tuberculosis.

Program Participation by Non-Students

Students come in daily contact with other members of the college community which includes all of the college staff, the administration, the faculty and other employees. Any one of these may have tuberculosis. Students would have added protection if all college employees were examined.

Student health services are in the best possible position to inform vast numbers of young people about tuberculosis, and must be prepared to meet this challenge.

Tuberculosis Among College Students, Seventeenth Annual Report of the Tuberculosis Committee, Chairman, Max L. Durfee, M. D., American Student Health Association, for the Academic Year, 1946-1947, The Journal-Lancet, November, 1948.

SOUTH TEXAS MEDICAL GROUP TO MEET AT SHAMROCK HOTEL

The Post Graduate Medical Assembly of South Texas will hold its fifteenth annual meeting at the new Shamrock Hotel, Houston, Texas, November 29th, 30th and December 1st, 1949. Physicians planning to attend are urged to contact the hotels of their choice as soon as possible for hotel accommodations. For further information address the Secretary, 229 Medical Arts Building, Houston, Texas.

DO'S AND DON'TS IN WRITING YOUR CONGRESSMAN

When Congress studies a bill, experience has shown that members of Congress do **not** always know how and why their legislative acts will affect their constituents, unless the latter write and tell them.

Your views are always welcome, for the men who stay in Congress the longest are those who read and heed their constituents' letters. **BUT** there's a right way to write effectively to your Congressman. May we offer these suggestions.

DO

- spell your Congressman's name correctly
- make sure whether he is a Senator or a Representative
- state concisely what you think and why—the briefer, the better
- subordinate your self-interest
- be sure of your facts
- cite specific illustrations, whenever possible, as to effects proposed legislation would have on business, and workers in your community
- write on your business stationery
- sign your name plainly. Type it under the signature
- send a letter rather than a telegram when time permits
- seize every opportunity to become personally acquainted with your Congressman

DON'T

- threaten political reprisals
- write in a captious or belligerent mood
- remind your Congressman of broken promises
- attempt to speak for anybody but yourself
- insert newspaper clippings or mimeograph material
- send a chain letter or postcard
- quote from form letters
- write only when you want a favor. Letters of commendation are always welcome
- try to make an errand boy out of your Congressman
- become a chronic letter writer
- United States Chamber of Commerce

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EDITORIAL

OUR PRESIDENT

Euclid M. Smith, Hot Springs National Park, installed as the Seventy-fourth President of the Arkansas Medical Society, April 16th, 1949, was born in Fannin County, Texas, January 10, 1902, and completed his studies at the Bonham, Texas, High School in 1921. Entering Texas A. & M. College for the two-year pre-medical course, he graduated in medicine from the University of Arkansas School of Medicine in 1929 and served an internship at Cleveland, Ohio, City Hospital, in 1929-30 and a medical residency at the Wade Clinic, Hot Springs National Park from 1930 through 1933.

His military service began with the call to active duty in May, 1942, as Major, M. C., A. U. S., and assignment to Ellington Field, Texas, as Chief of Medical Services. In 1943 he completed the course at the School of Aviation Medicine and received his flight surgeon's rating in March, 1945, having been promoted to lieutenant-colonel in November, 1943, and assigned to Pampa, Texas, Air Field, as Post Surgeon. In June, 1946, he was separated from service with

the rank of colonel, a rank he now holds in the medical reserve corps.

Medical organizations have had his enthusiastic interest from the beginning of his practice. He is a member of the Hot Springs-Garland County Medical Society, the Southern Medical Association, the Aero Medical Association and of the American Rheumatism Association, and is a Fellow of the American Medical Association, the American College of Physicians and of the American Therapeutic Society. At the time of his call to military service he was serving as Councilor from the Seventh District to the Arkansas Medical Society, an office to which he was re-elected upon return to civilian practice. Subsequently he served as chairman of the Council until his election as president-elect at the 1948 annual session.

A member of the Board of Trustees of the University of Arkansas he has been the active member of that body for the medical school affairs and has, in addition, been engaged in teaching activity at the School of Medicine as Instructor from 1934 to 1936, as Assistant Professor from 1936 to 1939 and as Associate Professor, Department of Medicine, Chief, Rheumatology Section, since 1939.

Other activities comprise, staff member, Charles Steinberg Clinic and Saint Josephs Hospital, Hot Springs National Park; consultant on arthritis, Missouri Pacific Hospital, Little Rock; Chairman, Southern Section, American Congress of Physical Medicine; Member, Committee on American Health Resorts, American Medical Association; Second Vice-president, American Therapeutic Society; Vice-chairman, Section on Physiotherapy, Southern Medical Association; Chief Medical Staff, Leo N. Levi Memorial Hospital, Hot Springs National Park, and Member, Council on Physical Medicine, American Medical Association.

His contributions to the literature are many and valuable, among them being "The Principles of Spa Therapy," Blumer's Loose Leaf System of Therapeutics; "Hydrotherapy in Arthritis," American Therapeutic Society Proceedings; "Spa Therapy in Rheumatic Diseases," Archives of Physical Therapy; "Health Resort Therapy in the United States," Proceedings of the American Therapeutic Society, and others.

He was married to Miss Madge Wootton, the daughter of W. T. Wootton, a former president of the Society, in 1934, and thus becomes the second son-in-law of a president to become president of the Arkansas Medical Society. The Smiths have two daughters, Lee, 2 and Gale, 6.

With a full experience in the affairs of the Arkansas Medical Society; an understanding of the problems of medical care in Arkansas as can only be gained from actual practice and the knowledge which comes to one who interests himself whole-heartedly in medical society activities; the demonstrated ability to bring ideas into realities; a vision of better medical educational facilities and of improved medical care in Arkansas; and above all, a truly altruistic desire to serve well his fellow-practitioner and the citizens of Arkansas, the Society will have cause to proudly follow his leadership.

STATE HEALTH COUNCIL

MR. SID WRIGHTSMAN, JR.

Executive Secretary

Initial steps towards the formation of a State Health Council in Arkansas were taken in Little Rock on May 6th when a group of representatives from voluntary, state and professional organizations met to outline procedures necessary in the activation of such an agency.

The representatives attending the meeting were indicative of an awareness among state organizations . . . voluntary and professional, alike . . . of the increasing need for a cooperative agency for coordination in the field of public health.

They included:

Charles R. Henry, Little Rock, and Joe W. Reid, Arkadelphia, Arkansas Medical Society; Mrs. Louis K. Hundley, Pine Bluff, Woman's Auxiliary to the Arkansas Medical Society; Mr. J. A. Gilbreath, Little Rock, Arkansas Hospital Association; Mrs. Howard Crawford, Arkadelphia, Arkansas Council of Home Demonstration Clubs; Mrs. J. L. Montgomery, Marianna, Parent-Teachers Association; Mr. Jack L. Redheffer, Little Rock, Arkansas Medical and Hospital Service, Inc.; T. T. Ross and Edgar Easley, Little Rock, Arkansas State Board of Health; Mr. Aubrey D. Gates and Miss Helen Robinson, Little Rock, Arkansas Extension Bureau; Mr. Waldo Frasier, Little Rock, Arkansas Farm Bureau and Dr. J. O. Hall, Little Rock, Arkansas Dental Association.

Doctor Ross and Mrs. Hundley reported on the recent regional conference in Kansas City of the National Advisory Council on Health. Both stated that the one major point—stressed throughout the conference—was the everpresent need of the State Health Council to make laymen aware of the existing health agencies that are open to them.

After further discussion about the leadership, financing and duties requisite to a successful health agency, it was decided that a large meet-

ing would be held in Little Rock during the last week of May, to which all county and state organizations interested in health matters would be requested to send representatives for an explanation about the proposed State Health Council and the necessary participation of each organization.

The following planning committee was appointed to complete plans for the state-wide indoctrination conference: Mr. Montgomery, chairman; Dr. Ross, Dr. Henry, Mr. Frasier, Mr. Gates and Mr. Redheffer.

"CANCER: THE PROBLEM OF EARLY DIAGNOSIS."

A new sound motion picture film, titled as above, has been made available to medical societies by its co-sponsors, the American Cancer Society and the National Cancer Institute of the United States Public Health Service. The film has received the approval of the American Medical Association's Committee on Medical Motion Pictures.

Expertly planned and executed, the film presents in audio-visual manner the importance of early diagnosis in cancer. County medical societies will enjoy and profit from its presentation and are advised to make application for a showing. The film may be obtained on application from the Arkansas Division, American Cancer Society, 315 Professional Building, Fort Smith, or from the Arkansas State Cancer Commission, State Health Office, Little Rock.

RANDOM THOUGHTS OF THE SECRETARY

April 21st. Comes the Johnson County Graphic with an account of the election of a home boy, Earle H. Hunt, to presidency-elect of the Arkansas Medical Society which reads, in part: "Dr. Hunt is now under study to the president * * *," and that, we contend, is really one for the books.

April 27th. "Fouled-up" air travel works to our advantage today although it leaves Peggy stranded in Muskogee much as Gay, Thompson were with us in Wichita once upon a time * * * flying to Little Rock and then with Rosenbaum off to Jonesboro, stopping for dinner, keeping the Jonesboro folks waiting, but they surely do not mind if they have eaten at Walnut Ridge's Salad Bowl, an eating house of satisfaction * * * and returning during the night for a short bit of sleep and away for duties at home on the morning flight.

April 30th. Meeting with the Kansas City Radiological Society tonight and touring the new Research Diagnostic Clinic, another Kansas City first in a series of medical accomplishments, and this particular one a monument to physicians who unselfishly served in the cause of better medicine by providing for accurate and complete diagnosis in an ethical manner and with reasonable cost.

May 1st. On a day with all the serenity, freshness and beauty of spring traveling down through the Ozarks, rest-

fully lounging aboard the Kansas City Southern and, in the late afternoon, to Camp Chaffee where we enjoy peacetime army social life with the assembled personnel * * * then with the Hawkins to the Dining Car for steaks, Jane and Wright being gracious hosts to the entire family, the youngster excepted, since they do not have a dog.

May 3rd. To Booneville to board the Rocket which serves excellent luncheon in the Rock Island pattern but seems to have lost its zip in speedy travel to Little Rock * * * again riding with Rosenbaum to El Dorado, briefly visiting Warner-Brown Hospital, soon to be a million-dollar institution * * * dining, after proper preliminaries in the grand manner of the Union County Medical Society, in the unusual Ming Room, and this time, we can visit the El Dorado physicians with neither apology nor humility, of which we avail ourselves as Rosenbaum speaks on the cancer commission functions and we discuss the proposed program for education of the public in voluntary medical care plans * * * returning, traveling hazardous U. S. 167 with many forlorn mules, cows and horses, each a positive threat to motoring and, perhaps, the boosters for good and better highways in Southwest Arkansas will some day insist that stock be kept behind fences.

May 12th. Riding with Krock to the Fayetteville cancer clinic where seventy or more come, among them a ten-year survival of ours who brightens our day * * * thence with Weddington as guide over the astounding Hathcock Clinic Building where we would like to have the parking, pin-ball and soft drink concession and to marvel at the number of facilities for physiological indulgence of staff and patients, probably as many as a Statler hotel—tarrying with the Siscos at Springdale for refreshment and surcease and to dine with the Benton county group at the Harris still serving good food well and engaging in a limited extent, as does not President-elect Hunt, in the discussions of the evening.

May 15th. Busy with committee session, the committee enjoying the Albert Pike's luncheon well, the President departing early in unaccustomed manner and perhaps he only had leave of absence for three hours to visit in Little Rock.

May 16th. By the airlines, a 35-mile headwind facilitating our passage to Kansas City and ahead of time for Lockwood's conference tonight, viewing all manner of diaphragmatic pathology and the day's output of myelograms—THREE!—such opportunity does this busy group afford!

May 20th. With Foltz making a return engagement to Waldron to take care of the overflow from the recent cancer diagnostic clinic, this time greeted by some 29 persons but mostly glad that the opportunity is afforded to discuss with important citizens that Waldron is now favored with competent physicians and that it becomes Waldron's duty not to permit their discouragement.

CORRESPONDENCE

18 May 1949

W. R. Brooksher, Secretary
Arkansas Medical Society

The Department of the Army is urgently in need of Public Health Officers to serve in a civilian capacity with the occupation forces in Japan. These positions, which involve supervision of Japanese prefecture (state) health de-

partments in all phases of preventive medicine and medical care programs, offer an excellent opportunity for broad experience in public health. We will greatly appreciate your assistance in locating qualified and interested candidates for this program.

Minimum acceptable qualification requirements are a degree in medicine plus one year internship. Experience in public health is desirable but not mandatory.

The salary for these positions is \$6,235.20 per annum plus 10% post differential with quarters provided at no cost to the employee. Individuals selected for appointment must agree to remain a minimum of two years. Transportation is furnished to and from Japan. Dependents may join the employee in approximately 6 to 8 months after his arrival in the command.

It will be appreciated if you will publicize this information and advise interested applicants to make formal application by submitting Civil Service Commission Standard Form 57 to this office. Forms may be obtained from any Class A Post Office.

The necessity for immediate recruitment of qualified and suitable personnel cannot be over-emphasized. Your assistance in this vital program will be most beneficial to the Department of the Army.

Sincerely yours,

CHARLES C. FURMAN

Chief, Recruitment Section
Overseas Affairs Branch
Civilian Personnel Division

May 9, 1949

Dr. J. Kenneth Thompson, President
Sebastian County Medical Society
Fort Smith, Arkansas
Dear Dr. Thompson:

I appreciate your sending me a copy of the Resolution of Sebastian County Medical Society, in regard to the President's health program.

I agree with you that passage of this legislation, as now written, would not be in the best interests of the country. I feel confident that the Congress will approve no legislation containing compulsory service features.

We must expand medical facilities but we can do this under a voluntary system that will avoid Government control and dictation.

Sincerely yours,

(Signed) BROOKS HAYS

PROCEEDINGS OF SOCIETIES

The First Councilor District Medical Society met at Tyronza May 9th for the following scientific program: "The General Practitioner's Responsibility as Related to Cancer," R. L. Sanders, Memphis; "What the General Practitioner Sees Through the Speculum," R. R. Braund, Memphis; and "What Can the Practitioner Do About Eclampsia," Frank E. Whitacre, Memphis. Following dinner, Morris Fishbein, Chicago, addressed the meeting on "One Hundred Years of Medicine."

Union County Medical Society met in dinner session at El Dorado May 3rd for the following program: "The Arkansas State Cancer Commission," Carl A. Rosenbaum, Little Rock, and "The AMA Educational Program," W. R. Brooksher, Fort Smith.

A. R. Clowney, Secretary.

A symposium on carcinoma of the breast was presented to the Sebastian County Medical Society May 10th by Fred H. Krock, S. W. Hawkins, W. R. Brooksher and A. S. Koenig.

J. B. Stewart, Secretary.

Greene-Clay County Medical Society met in Paragould on April 20th for the following scientific program: "Coronary Heart Disease," W. D. English, Cardwell, Mo.

Benton County Medical Society met in dinner session at Rogers May 12th for the following program: "Medical Aspects of Peptic Ulcer," J. Ken Thompson, Fort Smith, and "Surgical Aspects of Peptic Ulcer," Thos. P. Foltz, Fort Smith.

Geo. M. Love, Secretary.

The Fifth Councilor District Medical Society met in dinner session at Magnolia May 16th for the following program: "Coronary Heart Disease," Dan H. Autry, Little Rock, and "Carcinoma of the Fundus of the Uterus," Frank Kumpuris, Little Rock.

Charles L. Weber, Secretary.

The first Annual Session of the Arkansas Chapter, American Academy of General Practice, was held in Little Rock, April 13th. Speakers were: Sam Phillips, Barney P. Briggs, S. C. Fulmer, J. N. Compton, Gilbert Dean, Henry G. Hollenberg, Chas. R. Henry and Clyde D. Rogers, all of Little Rock, and Mr. Mac F. Cahal, Kansas City, Executive Secretary, American Academy of General Practice. The following of-

ficers were elected: President, Fount Richardson, Fayetteville; Vice-president L. H. McDaniel, Tyronza; Secretary-treasurer, W. B. Grayson, Little Rock; Delegates, G. L. Kimball, DeQueen, and R. B. Robins, Camden, and Directors, R. J. Haley, Paragould, S. A. Drennan, Stuttgart, John H. Wilson, Magnolia, Norman W. Peacock, Ashdown, Benjamin N. Saltzman, Mountain Home, Ralph G. Kramer, Fort Smith, L. T. Evans, Batesville, M. D. McClain, Little Rock, Gibbs Biscoe, Dumas, and C. R. Ellis, Malvern.

PERSONALS AND NEWS ITEMS

B. N. Saltzman has been elected president of the Mountain Home Rotary club.

The following have been appointed members of the State Medical Board of the Arkansas Medical Society: M. L. Harris, Newport; W. H. Poynor, Harrison (re-appointed); Chas. H. Lutterloh, Hot Springs National Park (reappointed), and G. D. Murphy, Jr., El Dorado.

W. J. Ketz, J. J. Monfort, and Paul Gray participated in a forum discussion on socialized medicine before the Batesville Rotary club April 25th.

R. B. Robins, Camden, addressed meetings of the Kansas and Nebraska chapters, American Academy of General Practice during May and also attended a meeting of the Executive Committee, American Medical Association, in Washington, for a consideration of legislative proposals on health matters in Congress.

Chas. R. Henry, Little Rock, addressed the Louisiana Conference of Social Welfare and Associated Groups at Shreveport May 5th on compulsory health insurance.

Dr. and Mrs. J. O. Cotton, Leslie, recently celebrated their golden wedding anniversary.

D. W. Goldstein, Fred H. Krock and W. R. Brooksher, Fort Smith, conducted a diagnostic cancer clinic at Fayetteville May 12 under the sponsorship of the Washington County Medical Society and the Arkansas Division, American Cancer Society.

Sam Phillips, Little Rock, attended the American Academy of Pediatrics at Atlanta during April.

WOMAN'S AUXILIARY NEWS



MRS. L. K. HUNDLEY

Pine Bluff

President, Woman's Auxiliary to the Arkansas
Medical Society
1949-1950

Mrs. G. F. McLeod and Mrs. Chas. Weber were hostesses at a luncheon meeting in April of the Columbia County Medical Auxiliary.

After the roll call and reading of the minutes, Mrs. Joe Rushton, the president, gave a report on the last day of the state meeting in Little Rock which she attended. Material on Socialized Medicine was distributed to each of the ten members present.

It was decided that the project for the year would be furnishing operative gowns for the City Hospital.

Mrs. E. G. Burt, City Chairman for the Cancer Fund Drive, asked for volunteers to help and two members responded.

Plans were made for entertaining members of the Fifth Councilor District who will meet here in May.

The Twenty-fifth Annual Meeting of the Woman's Auxiliary to the Arkansas Medical Society opened Thursday, April 14, in the Continental Room, Hotel Marion. Mrs. Carroll F. Shukers, President, Women's Auxiliary to the Pulaski County Medical Society presided. Mrs. W. C.

Langston of Little Rock gave the invocation. Mrs. T. Duell Brown, Little Rock, gave the address of welcome to which Mrs. P. W. Lutterloh responded. Mrs. Mason G. Lawson, State President, introduced the special guests. All reports of officers and committees were given.

The ladies of the Auxiliary enjoyed with the Medical Society two inspiring talks Thursday night at the Robinson Auditorium. Dr. Marjorie Shearon, of Washington, D. C., gave "The Scheme For a National Compulsory Health Insurance Program," and Mr. Cecil Palmer of London, England, told us "What Socialized Medicine Has Meant to Britain."

The Friday session opened with a talk by Dr. P. W. Lutterloh, President of the Arkansas Medical Society. Dr. Louis K. Hundley, Pine Bluff, Chairman of the Advisory Board, also addressed the group. An interesting feature of the morning session was the reports of Presidents of County Auxiliaries. The Auxiliary adjourned so that they could join the doctors at the Robinson Auditorium for a memorial service. Dr. L. H. McDaniel of Tyronza had charge of the program.

Mrs. Luther H. Kice, Garden City, Long Island, N. Y., was guest speaker at a luncheon Friday, April 15. Mrs. Mason Lawson, President, conducted the installation of 1949-50 officers, after which Mrs. Lawson presented the gavel to Mrs. Louis K. Hundley, newly elected President.

Friday evening the annual buffet dinner for doctors and their wives and sweethearts was held in Hotel Marion followed by dancing. Mrs. Hundley held a workshop Saturday morning, April 16. Mrs. Hundley presented each county president and state officer with workbooks for better informed workers. We were honored to have Mrs. Arthur A. Herold, our National Treasurer, speak at this meeting.

The 93rd Semi-Annual meeting of the First Councilor District was held in Tyronza May 9th. The ladies of the Auxiliaries to the Medical Society were entertained at a tea at "Fairview," the spacious home of Mrs. Hiram Norcross. Mrs. Marshall Wingfield of Memphis, Tennessee, gave an excellent review of Lilly Dache's book "Talking Through My Hat."

The ladies joined their husbands later at the school where a delicious barbecue dinner was served by the P.T.A. The highlight of the evening was a talk by Dr. Morris Fishbein, Chicago, Illinois, Editor of Hygiea and the A.M.A. Journal, speaking on "One Hundred Years of Medicine."

PROCEEDINGS, SEVENTY-THIRD ANNUAL SESSION ARKANSAS MEDICAL SOCIETY

Robinson Memorial Auditorium, Little Rock, Arkansas
April 14th, 15th and 16th, 1949

FIRST GENERAL SESSION

April 14, 1949—9:30 A. M.

The meeting was called to order by President Lutterloh.

The invocation was given by Rev. Paul V. Galloway, Winfield Methodist Church, Little Rock. The scientific program then followed in order.

"Pentothal Anesthesia Using Continuous Drip Method," B. E. Barlow, Dermott.

"Caution . . . Curves Ahead," Mr. Mac F. Cahal, Executive Secretary, American Academy of General Practice, Kansas City, Missouri.

"Puerperal Gynecology," Eugene T. Ellison, Texarkana (Lantern Demonstration).

"Hemochromatosis: Preliminary Report of a Case of a White Female without Diabetes Mellitus," Charles T. Chamberlain, Fort Smith.

"Rupture of the Pregnant Uterus," Hubert L. Allen, Alton, Illinois (Lantern Demonstration).

FIFTY-YEAR CLUB AWARD PROGRAM

The meeting was called to order by Earle H. Hunt, Clarksville, chairman, "Fifty-Year Club" program, who gave the presentation address.

It is a pleasure and honor to me to be asked to make the awards to the "Fifty-Year" members because I do know some of what all of you have gone through. This is the first time the Arkansas Medical Society has given you older doctors this most deserved recognition. Several other states have adopted this procedure and at last I am glad to say that Arkansas is following suit. I know that you fellows have filled in the gap from pioneering free family physicians up to now, where we are in danger of having socialized medicine thrust down our throats.

I am certain that each of you began your practice riding the horse and using the old-fashioned saddle bags and then gradually went to the horse cart, horse and buggy, and finally to the automobile. I know the many hours that you spent sitting around a cold house waiting for some poor mother to deliver a baby, spending the whole night and in many instances two or three days and nights, even to have the baby born while you were out in the yard. I am also sure that many of these families have never paid you one dime and haven't even come around to thank you or bring you a piece of ham or turnip greens. I just received a letter from Dr. Rhine, of Thornton, telling of his experience riding a horse out to make a call. It was raining, sleeting, freezing. His slicker was frozen stiff when he got to the house. He pulled his slicker off and stood it on the front porch and the slicker was nice enough to be standing up when he came back out to go home—still frozen. I am satisfied

each of you have had similar experiences and that you have been forced to walk on long calls and to swim cold streams at night in your efforts to take care of your patients. I know that all of you have put up with those things which would fill volumes, just as did Dr. Hertzler who wrote in his book "The Horse & Buggy Doctor." He didn't have any experiences that you have not had many times over.

I do not want to take up a lot of your time, but I do want to say that your county secretaries have been very negligent in reporting "Fifty-Year Members" as they were requested to do. We wish at this time to add the names of doctors whose county secretaries failed to report their names: Dr. E. F. Ellis, of Fayetteville, Dr. John Jenkins, of Pine Bluff, Dr. S. A. Southall, of Lonoke, Dr. Fred Youngblood, of Huntsville.

It has not been definitely decided how presentation would be made of pins for those members unable to attend. If a man has practiced fifty years he is entitled to this pin even though he was unable to be here.

At this time I have a piece of poetry I want to give you:

When in the cottage blessed with love's sweet store,
A babe is born and o'er the rustic door
Is hung the crown of motherhood, and fair
Is all within,
The Doctor's there.

When 'neath the pall of mystic death's weird spell,
A mother's heart is broken by the knell of all that's dear,
And on the stair no baby's feet,
The Doctor's there.

When virtue flees and breath of ruthless lust
Eats into the soul as does the gnawing rust
When no one else with her the shame will share
With mother's touch,
The Doctor's there.

Where blossoms life's sweet bud at blush of day,
Where breath of withered rose at evetide steals away
On the south wind in joy and care,
An uncrowned king,
The Doctor's there.

And that is what I think of you fellows—you are all uncrowned kings.

Presentation of awards to "Fifty-Year Club" members present was made by Chairman Hunt.

"50-YEAR CLUB" MEMBERS—1949

E. H. Abington, Beebe	F. M. Duckworth, Siloam Springs
B. L. Bailey, Star City	E. F. Ellis, Fayetteville
F. E. Baker, Stamps	F. G. Eubanks, Decatur
W. E. Ballenger, Plainview	M. Fink, Helena
B. L. Bennett, Van Buren	D. M. G. Frailey, Harrison
A. R. Colvin, Strong	J. C. Gilliam, Des Arc
J. O. Cotton, Leslie	W. B. Gould, Glenwood
W. H. Connell, Hot Springs	S. M. Graves, Clarksville
Allen Cox, Helena	J. F. Gullledge, Siloam Springs
Sam Daniel, Marshall	

J. F. Halbrook, Morrilton
 A. J. Harrison, Springdale
 A. R. Hederick, Booneville
 L. E. Henderson, Marble
 Thomas L. Hodges, Bismark
 W. H. Horn, Magnolia
 Elmer M. Hudson, Little
 Rock
 G. A. Hughes, Siloam
 Springs
 E. C. Hunt, Ola
 R. L. Hutcherson, Delaplaine
 J. S. Jenkins, Pine Bluff
 E. B. Jones, Hartford
 R. A. Jones, Perry
 T. S. Jordan, Magnolia
 J. C. Land, Walnut Ridge
 N. J. Latimer, Corning
 F. A. Lee, Vandervoort
 I. N. McCollum, Conway
 J. H. McCurry, Cash
 H. L. Montgomery, Gravelly
 W. A. Moore, Rogers
 J. J. Morrow, Cotter
 H. Moulton, Fort Smith

E. P. McGehee, Sr., Lake
 Village
 J. F. McKnight, Bradley
 J. H. McLean, Caddo Gap
 M. L. Norwood, Lockesburg
 A. L. Peacock, Gentry
 Braxton V. Powell, Camden
 J. W. Ramsey, Jonesboro
 T. E. Rhine, Thornton
 W. F. Rogers, St. Joe
 Horace E. Ruff, Little Rock
 J. O. Rush, Forrest City
 W. C. Russwurm, Helena
 Zuber N. Short, Hot Springs
 J. R. Sloan, Garner
 S. A. Southall, Lonoke
 W. H. Toland, Nashville
 C. C. Townsend, Walnut
 Ridge
 W. W. Verser, Harrisburg
 Sam D. Weil, Hot Springs
 J. B. Wharton, El Dorado
 C. E. Wilson, Blytheville
 Fred Youngblood, Huntsville

Response was made by J. H. McCurry, Cash, as follows:

I am sure all of us are thankful and appreciate the honor bestowed upon us for having survived, lived through and practiced medicine fifty years and are justly proud of this accession to our state society. I don't know that we have anyone especially to thank for this honor except that the Lord saw fit that we be born at an earlier date than you younger gentlemen. If you are as fortunate to survive long enough the honor will creep upon you much more quickly than you may suppose. Any doctor who has practiced the healing art conscientiously and legitimately fifty years has had honor and glory enough from the friends he has gained and other achievements that have come his way.

It makes very little difference where we are or where we live if we are intensely interested in humanity and love our work; success will crown our efforts. But we do like to do things just as we like to do them our way. So let's not bow down to socialized medicine—it's a dang good idea to do things like we like to do them.

Bill Nye started a newspaper in Laramie, Wyoming, and his office was over a livery stable, so he put a sign at the bottom of the steps, and on the sign it said, "To get to the editor's office just step inside and twist the gray mule's tail and take the elevator." Bill Nye was his own boss, and he could write what he wanted in the way he wanted it, and from that office over the gray mule's stall he rode to fame.

All of us want to go on and do as we have been doing and not be hampered by socialized medicine.

Our American way of life is made up of many things—automobiles and chewing gum, television and ice cream, colossal educational universities and the little red schoolhouse where most of us learned our A.B.C.'s and we still know them. It provides each individual an opportunity to go as far and climb as high as his willingness to work, his skill, ingenuity and integrity will carry him. Our American way of life recognizes that the individual has the right to work when and where he pleases, to speak our mind on any subject, to meet with our fellowmen for any peaceful purpose.

These things have created an economic effect which

made possible in this country the greatest production and diffusion of wealth in the history of the world.

Our American way of life has also resulted in giving sick folks better care and service than can be obtained anywhere in the universe. So let's hold what we have and go forward in the sure faith that the American way of life is the greatest blessing known to mankind on the face of God's good earth.

Again we thank you.

SECOND GENERAL SESSION

April 14, 1949—1:30 P. M.

The meeting was called to order by President Lutterloh.

The following scientific program was presented by the faculty of the University of Arkansas School of Medicine:

"Wire Sutures . . . Surgical Status and Technical Aspects," Gilbert O. Dean, Professor and Head of the Department of Surgery.

"Intra-Vascular Clotting," Carl Rosenbaum, Associate Professor of Surgery.

"Treatment of Purulent Meningitis," William A. Reilly, Professor and Head of the Department of Pediatrics.

"Anticoagulants in Heart Disease," R. E. McLochlin, Associate Professor of Medicine.

"Prejudicial Practice in the Management of Eclampsia," Willis E. Brown, Professor and Head of the Department of Obstetrics and Gynecology (Lantern Demonstration).

"Fractures of the Spine Following Electric Shock Therapy," I. Meschan, Director of Radiology (Lantern Demonstration).

FIRST SESSION, HOUSE OF DELEGATES

April 14, 1949

The meeting was called to order at 4:00 P. M. by President Lutterloh.

The Credentials Committee (A. D. Garner, Fount Richardson) reported that the credentials of the delegates present had been examined, found correct and that a quorum was present.

By motion (Harris-Richardson) delegates' credentials were accepted in lieu of roll-call.

The following delegates and county society members seated as delegates by action of the House of Delegates (motion Fount Richardson-Earle Hunt) were present:

CHICOT—J. H. Burge; CLARK—J. R. Barnett; CLEVELAND—W. G. Hancock; COLUMBIA—G. L. Weber; CRAIGHEAD-POINSETT—J. H. McCurry; CRAWFORD—S. D. Kirkland; CRITTENDEN—L. C. McVay; CROSS-ST. FRANCIS—A. F. Barr, J. O. Rush; DESHA—H. T. Smith; DREW—Van C. Binns; FAULKNER—L. L. Hassell; GARLAND—E. D. Rowland; GREENE—

CLAY—A. D. Garner; HOT SPRING—H. L. Brown; INDEPENDENCE—O. J. T. Johnston; JEFFERSON—Fred Hames; JOHNSTON—J. M. Kolb; LAFAYETTE—R. H. Harrison; LAWRENCE—J. C. Land; LINCOLN—C. W. Dixon; LITTLE RIVER—Elmer Davis; MADISON—Charles Beeby; MILLER—H. E. Murry; MISSISSIPPI—C. E. Wilson; NEVADA—G. G. Hairston; PHILLIPS—J. B. Terry; POLK—F. A. Lee; POPE-YELL—Roy I. Millard; PRAIRIE—J. C. Gilliam; PULASKI—T. D. Brown, D. H. Autry, Fred W. Harris, Hoyt R. Allen, John W. Smith, John Samuel, Frank Kumpuris; Geo. R. Steinkamp; Robert D. Jones, Elvin Shuffield, Edwin F. Gray; RANDOLPH—W. E. Hamil; SEARCY—W. T. Moore; SEBASTIAN—A. F. Hoge, F. H. Krock; SEVIER—C. E. Kitchens; UNION—G. D. Murphy, Jr.; H. J. Mayfield; WASHINGTON—Fount Richardson; WHITE—Porter R. Rodgers.

Other members of the House of Delegates present were:

President Lutterloh, President-Elect Smith, Vice-President J. O. Rush; Councilors R. C. Dickinson, Ellery C. Gay, John H. Wilson, L. G. Martin, D. L. Owens, Earle H. Hunt, L. H. McDaniel and Louis K. Hundley; Past-Presidents R. B. Robins, O. J. T. Johnston, Sam J. Allbright, M. L. Norwood, H. King Wade and H. T. Smith; Treasurer Paul L. Mahoney and Secretary W. R. Brooksher.

L. H. McDaniel introduced S. W. Colquitt, fraternal delegate from the Mississippi State Medical Association to the Arkansas Medical Society.

By motion (Hunt-McDaniel) the minutes of the Seventy-second Annual Session as published in the June, 1948, issue of *The Journal of the Arkansas Medical Society* were adopted as correct.

President Lutterloh briefly addressed the House of Delegates, expressing gratitude to the Arkansas Medical Society for the honor extended him upon being chosen as President. In addition, he expressed thanks to all members for their cooperation during his term as President.

Committees of the Society then reported in order, each report being referred to the Reference Committee.

COMMITTEE ON ARRANGEMENTS

JEFF BANKS, Chairman

H. Elvin Shuffield reported for the committee, giving information on the public meeting and social functions planned during the session.

COMMITTEE ON SCIENTIFIC WORK

JOE B. WHARTON, Chairman

COMMITTEE ON MEDICAL LEGISLATION

JOE F. SHUFFIELD, Chairman

Mr. President and members of the House of Delegates:

The recent session of legislature closed one month ago and required much time and effort of your legislative committee. We have never worked with a more courteous legislature. The representatives and senators generally demonstrated their desire to do what the doctors of their districts wanted them to do. They have a high regard for their family doctor and our profession. By far the larger number of the members of the legislature are in favor of high medical standards. Very few would give any time to cultist or anyone else that wanted to talk derogatorily about our profession.

The committee wishes to thank every individual doctor that we called upon to help us. We know of no one that failed to do what we asked them when called by phone or by letter to do a certain thing. So long as we pull together like that we cannot fail.

In April, 1947, we were able to get a favorable opinion from the office of Attorney General Guy E. Williams stating that anyone obtaining license without a Basic Science Certificate of Proficiency in the Basic Science subject was subjecting himself to the possibility of being prosecuted. Following this, we were able with the help of the late Governor Bailey and his associate, Attorney Eugene Warren, to get Attorney Edwin E. Dunaway to prosecute the chiropractor board in the district criminal court, obtaining a conviction on March 22, 1948. This was appealed to the Supreme Court and the Supreme Court sustained the conviction handed down in Judge Gus Fulk's court. In other words, the Supreme Court has held that the Basic Science law is constitutional, or good.

During the recent session of the legislature, your committee studied a number of bills, some of which became law and some failed. Attached is a copy of the bills.

Your committee wishes to call to the attention of each and every doctor that all of our laws concerning the practice of medicine and specifically who shall practice medicine are now clear. If any doctor knows of anyone illegally practicing in his community or anywhere in the state, he should notify the Examining Board of such cases. Without such cooperation with the Examining Board, we cannot expect the Board to do its work efficiently. Better still would it be that we educate a layman with nice personality and plenty of energy to be employed by the State Medical Society, the Medical Examining Board, and the Basic Science Board jointly to carry on such work. In most instances, the doctor knowing of such misconduct will be too busy to do much about it, but if someone is employed to do this then it will be done. Attached you will find a letter from Dr. Gebauer who is Secretary of the Basic Science Board, concerning the subject of a layman being employed to ferret out and see that prosecution is carried out on violations of the medical practice act.

The following bills were introduced in the State Legislature, but failed to pass:

S. B. 75 (Baker)—Required premarital test; as amended passed the Senate but failed in House.

S. B. 109 (Budget Committee)—Appropriated \$50,000 annually for the Cancer Commission from the Public Welfare fund. Withdrawn. (A later bill was passed which appropriated \$25,000.)

S. B. 183 (Abington) (Optometry)—Repeals Section

10752 of Pope's Digest requiring a license for practice of optometry. Withdrawn March 9, 1949.

S. B. 230 (Abington)—Repeals Act 147 of 1929 which is the "Basic Science Law." Withdrawn March 9, 1949.

S. B. 255—Requires that enrollment at University of Arkansas Medical School be increased to minimum of 150. Withdrawn March 9, 1949.

S. B. 288 (H. B. 402) (by G. Jones and Campbell)—Appropriates \$6,200,000 for State Medical Center. Levies for collection only in 1950, State ad valorem tax. Withdrawn March 9, 1949. (H. B. 402 still in Committee.)

H. B. 159 (Van Dalsem) (Chiropractors)—Would exempt certain chiropractors from Basic Science test. Withdrawn January 31, 1949.

H. B. 334 (Turner)—This Act would have allowed dentists and vets as well as licensed physicians to dispense barbiturates. Failed.

H. B. 236 (Walther)—The purpose of this bill was to provide qualifications and control the selection of students at the University of Arkansas Medical School and to adjust tuition of students relative to practice of medicine inside or outside the State of Arkansas. Failed in House.

H. B. 363 (Peebles)—Directed Board of Trustees to require medical school admissions committee to prorate vacancies in the freshman class on a population basis according to Congressional districts. Failed.

Senate and House bills passed by the 57th General Assembly which affect the Arkansas Medical Association:

Act 79 (H. B. 210, Coffelt)—Provides that time in Armed Service practicing medicine will be accepted toward qualifications for County Health Officers.

Act 105 (H. B. 156, Budget Committee)—Appropriates \$1,200 annually for operation of the Basic Science Board.

Act 109 (H. B. 273, Budget Committee)—Reimburses the University Medical School and Hospital for aid, treatment, and relief for patients certified to the hospital by the Welfare Department, and for other purposes. Two hundred thousand dollars each year.

Act 131 (H. B. 23, Houses, Turner, Long, Mathis and Harvey)—Created a student financing Board; providing a loan fund for the aid of medical students in the University of Arkansas School of Medicine needing financial aid to complete their education.

Act 240 (H. B. 56, Dunn)—Provides pneumothorax treatment for tuberculosis patients who have been certified by the Superintendent of the State Tuberculosis Sanatorium to receive such treatment by physicians having been authorized to give such treatments.

Act 258 (S. B. 275, Rogers)—Requires doctors, hospitals, and others to report treatment of knife and gunshot wounds to peace officers.

Act 283 (H. B. 52, Howell)—Provides that every inhabitant of this state of sound mind twenty-one years old or older may prescribe for the disposition to be made of his body or any part or organ thereof after death.

Act 302 (H. B. 385)—Adds two members at large to the State Board of Health, one being a druggist and the other a dentist.

Act 346 (H. B. 363, Peebles)—The purpose of this Act is to perfect a fair distribution of the students at the University of Arkansas School of Medicine. The selection of freshmen medical students will be accomplished competitively within each Congressional District. Applicants from counties of low population will be given priority within each Congressional District when such applicants are willing to certify their intent to practice medicine upon the completion of their training in a community of 2,000 or less.

Act 356 (H. B. 313, Colay)—This act amends Act 147 of 1929, the "Basic Science Law," by adding to the five basic sciences therein named the subject of hygiene. Tests will be given on six subjects instead of five.

Act 412 (S. B. 249, Budget Committee)—Appropriates \$25,000 annually for maintenance and operation of the Cancer Commission.

Act 473 (S. B. 283, Screeton)—Provides for hospitalization of alcoholic patients at the State Hospital. Hospital may refuse patient who has received treatment within 12 months preceding his certification for admission. Will be admitted if there are any unoccupied beds.

Act 492 (S. B. 356, Fagan and Jones)—Provides for proposed State Medical Center and makes appropriations therefor in the amount of \$6,200,000.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

EUCLID M. SMITH, Chairman

This report of the Committee on Medical Education and Hospitals of the Arkansas Medical Society is an interim report believed to be necessary to acquaint you with the present situation at the School of Medicine.

The graduation exercises of the School of Medicine were held in Fayetteville on June 4 and 5 of this year. There were fifty-five (55) graduates who received their medical doctor's degree on this occasion. The ceremonies were colorful and the medical group added considerable to the dignity of the occasion. You are, of course, aware that the medical doctor's degree is the highest degree offered by the University of Arkansas. Again, the Councilors and various officials of the Arkansas Medical Society were invited to participate in these ceremonies and to join in the procession with officials of the University. They were seated on the stage in a place of honor. The "Oath of Hippocrates" was administered by Dr. P. W. Lutterloh, President of the State Medical Society.

At a meeting of the Board of Trustees on June fourth, the operational budget for the year 1948-49 was presented for their consideration. This budget envisioned the expenditure of \$1,113,183, which required an appropriation of \$112,983 from contingent cash reserves of the School of Medicine. You will remember that the total state appropriation for the operation of the School of Medicine was \$560,000 for each year of the biennium and the State Welfare Association donated \$200,000 each year of the biennium to assist the University Hospital in its operation. The remainder of the monies came from various income sources.

At a later meeting of the Board of Trustees the proposition of deficit operation entered into the discussion and it was decided at this time to increase student tuition fees to \$500 a year for each resident student and \$750 a year for each non-resident student. This announcement came just prior to the opening of the fall term of the School of Medicine and was not well received by the student group, who by resolution to the President of the Board of Trustees and the President of the University of Arkansas requested a hearing in the matter of increased tuition fees. This hearing was granted and Dr. Lewis Webster Jones, President of the University; Mr. Herbert L. Thomas, President of the Board of Trustees; and Dr. Euclid M. Smith, Chairman of the Medical School Committee of the Board of Trustees, met with representatives of the Student Council, representatives of various affiliated veterans' organizations and representatives of the Legislative Council of the State Legislature on Octo-

ber fifth in the amphitheatre of the medical school building. The discussions were general and the following day Dr. Jones queried the various Board members at the suggestion of the President of the Board of Trustees about this matter. Following these telephonic conferences it was decided to reduce the tuition fees to \$375 a year for each resident student of the State of Arkansas.

No change was made in the non-resident tuition fees. This will increase the income from this source to where it would now appear that the deficit operation would be slightly under \$100,000 for this year.

There is attached hereto a copy of the bulletin of the University of Arkansas School of Medicine, dated September, 1948, in which you will find the rules and regulations for the operation of the School of Medicine as well as a completely revised curriculum. (Tab. A.) This curriculum is the result of a practically continuous operation of the Curriculum Committee of the School of Medicine and is patterned after a composite of curricula of sixteen (16) medical schools presently operating in the United States.

After the untimely death of Mr. Ray Burks, of the firm of Burks and Anderson, who was the architect employed by the Board of Trustees to plan the Memorial Hospital, the Board of Trustees awarded the contract to Mr. Bruce Anderson, who was a co-member of the firm. Mr. Anderson during the past several months has discussed with each individual head of a department of the School of Medicine the needs and requirements of floor space for a new medical school building and the space requirements in the Memorial Hospital. In addition, Mr. Anderson and the administrators of the School of Medicine have examined the total overall requirements needed to build a medical center. It is believed at this time that the cube space requirement is fairly firm and Mr. Anderson is projecting to the Board of Trustees an estimated cost of construction, both at the present site of the medical school and at the medical center. Attached hereto is intimate detailed information about this matter. (Tab. B.)

You will recall the publicity that was initiated by an editorial in the Arkansas Gazette concerning the lack of facilities to treat cancer cases at the medical school. A total of \$2,855 was received by donations from citizens of this state. This amount of course was inadequate to purchase the necessary equipment and a grant was requested of the Cancer Control Division of the U.S.P.H.S. and from this source the school received \$21,000 for the purchase of this equipment. This equipment has been purchased, installed and in operation are three units which are used for treatment purposes: a 400 KV unit, a 250 KV unit, and a 100 KV superficial unit, the latter being on hand prior to the reception of this grant. The various items of equipment were advertised and bids were received and in each instance the low bidder was given the contract to furnish the equipment. In advertising a composite description was made so that all companies could bid on this equipment.

You will all recall the arrangements that the School of Medicine made with the State Medical Society in connection with the operation of a School of Technology, which was aimed to produce medical technicians that could be utilized by the physician in his office. Requirements for admission were high school graduation. The arrangements which were made allowed the Councilor of each district to appoint two students to the school with the understanding that these students would flow back, after they had completed their training, to the district from which they were appointed. This idea apparently

was not well received as we had but a few applications under this plan. Therefore, it was decided to revert back to our former status in the training of medical technologists, and presently in operation is a School of Medical Technology which has been approved by the American Society of Clinical Pathologists. Applicants who have received directional pre-technical training and have completed three years in an accredited college are eligible, upon the completion of one year of formal training, for a Bachelor's degree in Medical Technology and registration by the American Society of Clinical Pathologists. Those who have received only two years of training are eligible for registration only upon the completion of the one year of training in the School of Medicine Technology. At the present time there are 17 students in this school and applications are on hand to increase the student load to about thirty. It is proposed to stagger the registration so that there will be a constant flow of graduates from the school. Presently operating under the Department of Radiology is a school of radiological technicians. These students are required to spend a year in residence in such training. They are required to spend an additional year working with a Diplomate of the American Board of Radiology in order to be eligible for registration by the American Registry of X-ray Technicians or they may spend two years working for a non-board member and become eligible for registration.

It is conceivable that the School of Medicine develop a school of medical record librarians in the immediate future. At the present time a study is being accomplished to determine the feasibility of this program. There is no doubt in the minds of the authorities of the School of Medicine as to the need for such a school as under the present building program the State of Arkansas will within the immediate future build a number of new hospitals and skilled assistance will be needed to develop the records of these hospitals in accordance with the standards set up by the various registering organizations.

The School of Medicine has been most happy to participate in the programs of many of the county and district societies. This relationship has been quite stimulating and we sincerely hope that the various faculty members of the School of Medicine may continue to participate in these programs and that they be privileged to participate in the programs of the Arkansas Medical Society. In this connection the Committee on Programs has in the past been most generous with the allocation of time for the School of Medicine. In addition, two post-graduate assemblies have been held at the School of Medicine, and in each instance this project was sponsored jointly by the State Board of Health, the School of Medicine and the Committee on Post-graduate Education of the Arkansas Medical Society.

To enable the Department of Medicine to capture additional beds for teaching purposes in the University Hospital, a portion of the physical plant has been modified so that the Department of Medicine now has eight additional beds.

The Veterans Administration offered to the School of Medicine the opportunity of developing clerkships at their Facility in North Little Rock. This clerkship has been developed and, it is believed, will offer a very fine training and adjunct to the present facilities.

The U.S.P.H.S. through the State Board of Health has developed a very fine program devoted principally to venereal disease control at their hospital in Hot Springs, and senior students of the School of Medicine rotate through this hospital for a period of two weeks. In addition, the Army and Navy General Hospital in Hot

Springs has kindly offered two mornings each week where the student group assigned to the venereal disease program makes ward rounds on the medical service at that hospital. At the Army and Navy Hospital the cases studied are those in the rheumatological and cardiological sections.

Senior students also rotate through the Arkansas Tuberculosis Sanatorium at Booneville, where they remain two weeks under Dr. J. D. Riley. This particular function has also received fine commendation by the student group.

Beginning in July an integrated intern and resident training program was initiated. This involves the rotation of interns and residents in some of the specialties through the services at St. Vincent's Infirmary, the Baptist State Hospital and the University Hospital. This program of training has been favorably received by the intern group and presently on hand are applications from 33 members of the present senior class and three from graduates of other schools.

Active resident programs have been developed for training in the following specialties: surgery, medicine, pediatrics, pathology, obstetrics and gynecology, and radiology. All these programs have been approved tentatively by the Council on Medical Education and Hospitals of the American Medical Association.

A close working affiliation with the State Hospital for Nervous Diseases wherein the Departments of Medicine, Surgery, Obstetrics and Gynecology, and Pathology are active in processing and treating type cases at the State Hospital.

Following the departure of Dr. E. Lloyd Wilbur from the Baptist State Hospital, a tentative working arrangement was made with the School of Medicine and the Board of Trustees of the Baptist State Hospital to cover the Department of Pathology at that hospital. The Department of Pathology of the School of Medicine is presently functioning in a temporary manner for the Baptist State Hospital. The total fees received from this operation is \$7,000 each year.

The State Board of Health is authorized by law to develop a State mental hygiene program and received a sizable grant from the U.S.P.H.S. to accomplish this purpose. Following several conversations between medical school authorities and authorities of the State Board of Health, a decision was reached to utilize the Department of Neuropsychiatry in the School of Medicine and to develop this program locally as an initial venture. A sum of \$7,500 was received from this grant source for the purchase and erection of two temporary buildings. These were purchased from the War Assets Administration. These buildings have been set up just behind the medical school building and house the Department of Neuropsychiatry and the personnel of the Mental Hygiene Clinic, which consists of a clinical psychologist, a psychometrist and clerical help. By means of our affiliation with the Veterans Administration the various psychiatrists at the Veterans Administration and the various psychiatrists at the Veterans Facility in North Little Rock donate their time to this project. The initial grant of \$7,500 was supplemented by an additional \$3,500 which came from school sources. These monies as aforementioned were used in the purchase, installing and equipping of two buildings.

The School of Medicine also is closely affiliated with the State Board of Health through the provision of maternal and infant care, the Department of Pediatrics being completely subsidized from this source. To enable the School of Medicine to X-ray the chest of all patients at the clinic and hospital, the Tuberculosis Division of the

State Board of Health donated one complete photo-roentgen unit, which has been installed in the clinic section of the School of Medicine.

Through the good offices of Dr. John T. Gray, Medical Director of the State Welfare Association, and from federal sources several units of equipment have been purchased for the School of Medicine, among which is a 500 MA radiographic and fluoroscopic X-ray unit and a combination electro-cardiogram-stethogram, which will be most useful in diagnosing and in following the progress of rheumatic fever sufferers in the clinic.

The school also houses the clinic operated by the Crippled Children's Division of State Welfare Department.

There were two hundred thirty (230) applications from bona fide residents of the State of Arkansas for admission to the present freshman class. Ninety-one were selected on a competitive basis. In developing a competitive system of selection, the Committee on Admissions of the School of Medicine gives weights and values to the various attributes of applicants: scholastic standing, comparative scoring on the Professional Aptitude Test, military service and recommendation of the Pre-medical Advisory Committee. These are carefully evaluated and quality points developed, and the individuals with the greatest number of quality points are chosen. One female negro applicant was accepted for this freshman class out of twelve negro applicants.

At the time of matriculation there were three hundred five (305) medical students in the School of Medicine, divided in the following manner: Senior class 54, junior class 71, sophomore class 89, and freshman class 91. Also presently enrolled are six graduate students, seventeen students in the School of Medical Technology, and nine students in the course of X-ray Technique.

The patient load level at the University Hospital has been greatly increased over the first quarter of this fiscal year as compared with the first quarter of the last fiscal year—thirteen (13) per cent, or in absolute numbers, an average daily census of 176 for this period in 1948 and 155 in 1947. The clinic load has also been increased over last year. For the first six months of 1948 there were 2,868 new admissions and for the same period in 1947 there were 2,507 new admissions. Clinic visits for the first six months of 1948 totaled 29,366 and for the same period in 1947 clinic visits totaled 19,429. Attached hereto is a compilation showing patients discharged from the University Hospital. (Tab. C.) The accountants inform me that during the fiscal year ending June 30, 1948, the cost was \$.61 per patient per day and that the cost of each clinic visit was \$2.61.

For several years the University of Arkansas Blood Bank, which was conceived during the last war, has gone to many centers in our State and received whole blood from donors. This whole blood has been processed into dried plasma, which is stored and available when needed. This dried plasma has been shipped to many hospitals in the State, and on many occasions criticism has been offered to the aforementioned procedure, chiefly from pharmaceutical houses which are selling dried plasma commercially. To enable the School of Medicine to continually have on hand a sufficient amount of dried plasma for any catastrophe or emergency that might arise in our State, the Councilors were propositioned on the development of a program wherein county medical societies would arrange with the Blood Bank officials to develop a sufficient number of donors to make it profitable for the portable equipment to be sent to a location for the purpose of receiving such blood, with the view of processing this blood into dried plasma and shipping it di-

rectly back to a designated official of the county medical society who would be responsible for a proper utilization of this plasma. County society officials were queried by letter in this matter and to date only three county societies have responded. A trip was made to Washington County last week but was not profitable because only about one-half dozen donors were available. The other two counties heard from were Chicot and Pulaski, and arrangements have been made with these two counties for blood letting dates. It is the intent of the School of Medicine to again invite the officials of county societies to participate in this program.

During the past several years the State Board of Health Hygienic Laboratory has received surgical tissues from various physicians and hospitals throughout the State. The physicians of the Board of the State Board of Health, believing this function not to be a responsibility of the Hygienic Laboratory, decided to discontinue this function and, believing that in most instances the surgical tissues received were from medical indigent patients, the Department of Pathology of the School of Medicine decided to undertake a continuation of this function. Each physician of the State was made aware by letter of the intent of the School of Medicine in this connection. In this program the physicians of the State accepted the responsibility of determining medical indigency and sending surgical tissues to the Department of Pathology from those who are unable to pay a pathologist for an analysis.

You are aware that the operating budget of the School of Medicine became an integral part of the budget of the University of Arkansas and was presented to the pre-budget committee and later to the Legislature during the General Assembly of 1947. This procedure will again be followed and the School of Medicine budget will be presented to a committee of the Legislative Council prior to the convening of the 1949 General Assembly. The operating budget of the School of Medicine, which includes new construction, has been approved by the Board of Trustees. The extent of new construction is dependent upon the decisions reached by the Legislative Council. Briefly, the state appropriation necessary to carry on the operation of the School of Medicine and University Hospital for the biennium is slightly over \$2,000,000, which does not include any assistance from the State Welfare Department. A discussion of the cost of new construction is contained in the attached study.

The aims and objectives of the School of Medicine were submitted to the President of the University of Arkansas soon after he assumed office and he approved in principle these aims and objectives. Attached hereto is a copy for your information (Tab. D). You will note that one of the objectives is the establishment of a school of nursing, the graduates of which would be eligible for a baccalaureate degree in nursing. The Board of Trustees has gone on record as approving the development of a school of nursing, the time and place being dependent upon the desire of the people of the State to make the necessary monies available for new construction and operation of such a project.

Contained in the bulletin of the School of Medicine is a listing of all faculty members. It will be noted that a number of these faculty members reside in cities other than Greater Little Rock and utilization will be made of these faculty members who reside outside of Greater Little Rock from time to time in the teaching of the specialty in which he or she is particularly interested.

It will be well to point out the basic philosophy which has been adopted by the Board of Trustees and the authorities of the University of Arkansas in connection

with the type of graduate that the School of Medicine should produce. Basically, the authorities of the School of Medicine believe that its graduates should be well trained in the various phases of medicine so that they are best fitted to become general practitioners. The medical school authorities believe that in the development of a medical center every opportunity should be given to physicians of the State of Arkansas to pursue short post-graduate courses at the School of Medicine and believe further that the School of Medicine should be carried to the physicians of the State by means of forum and seminar discussions.

Because of the marked increase in patient load in the Isaac Folsom Clinic and University Hospital, the Director of Administration decided to undertake a study to determine the financial status of all new patients that were admitted to the clinic. Before such a study could be accomplished, medical indigency had to be analyzed and described in terms of degree. Attached hereto is a booklet which describes patient classification (Tab. E). It will be observed that all patients are classified into the numerical categories based on total family monthly income and number of dependents and in other pages are described the fee schedule of patients by category. Before proceeding in this direction, the School of Medicine desires that the Councilors of the Arkansas Medical Society approve this method of classification and fee schedule. It would be well to point out that all patients classified in "D" category are considered to be patients who are not medical indigents and who can be referred to a physician of their own choosing for medical service. It would appear only fair that those who can make some contribution toward the operation of this service should make a contribution in keeping with their financial ability, and it is further believed that by so doing patients will not be humiliated by the fact that they are, strictly speaking, charity patients.

Considerable publicity has been given in connection with the relationship between the School of Medicine and Dr. Joseph T. Roberts. The facts involved are as follows: Various faculty members and department heads went to the administrative head of the School of Medicine from time to time informing him of deficiencies that involved Dr. Roberts. Conversations were had between the administrative head and Dr. Roberts, and the President of the University was made aware of these happenings as well as the Board of Trustees. The President saw fit to inform Dr. Roberts that his contract would not be renewed after December 31, 1948. This communication was marked "Confidential." In this way Dr. Roberts was given the opportunity of gracefully withdrawing from his position without any publicity whatsoever. However, he saw fit to take issue with the action taken by the President of the University and solicited the sympathy of many of the local physicians, who found themselves more or less bewildered by the resultant situation. For this reason a meeting of the Liaison Committee of the Pulaski County Medical Society was held and attended by several other members of the Pulaski County Medical Society as well as the President of the University and the Vice-President for Medical Education and Hospitals, wherein the events leading up to the aforementioned letter were discussed with the group as well as the resignation of Dr. Roberts as Dean and administrative head of the Department of Medicine. These discussions were free and open, and it was felt that all those attending this meeting were completely conversant with this unfortunate situation.

Dr. William Cleaver Langston, head of the Department of Anatomy, was nominated and appointed Acting Dean

during this interim period until a new Dean could be selected. The Executive Council of the School of Medicine has accepted a more dominant role in the administration of the School of Medicine.

Dr. John Nye Compton was recommended by a committee to become the head of the Department of Medicine and Dr. Phillip J. Almaden to become his Executive Assistant. These appointments have been consummated by the President of the University of Arkansas.

Following a meeting of the Liaison Committee and other members of the Pulaski County Medical Society with the officials of the School of Medicine, the attached letter was dispatched to the President of the Pulaski County Medical Society, and the present policy adopted by the School of Medicine is one of comprehensive co-operation with the local physician group in the City of Little Rock (Tab. F).

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

T. T. ROSS, Chairman

The need for certain basic public health legislation has handicapped efforts to establish and maintain adequate local health services throughout the state. Though the State Board of Health has carried on an intensive recruitment program for public health personnel there is still a shortage. As of December 31, 1948, there were eleven full-time health officers; one assistant health officer; three full-time nutritionists; one dietitian consultant; one full-time health educator; one hundred eleven public health nurses; nine clinic nurses; forty-nine sanitation personnel; and seven venereal disease case investigators.

For carrying on the local health services the state now has seventeen district health departments with two to five counties each; eight full-time single county health departments; two full-time city health departments; and ten counties organized for nursing services only, twenty-two counties are without public health nursing services.

If the local health units are to provide the basic health services for the people certain basic permissive legislation is necessary. Two bills pertaining to local health service will be introduced in the 1949 General Assembly. One of the bills would permit two or more adjacent counties to pool their facilities and resources to form a district or multi-county health department. The second is a proposed amendment to the constitution to permit counties to vote a millage tax for public health service. If these two bills are passed by the 1949 General Assembly the task of developing adequate local public health services should be much easier.

The six primary health services commonly accepted as essential are: (a) vital statistics, (b) communicable disease control, (c) environment sanitation, (d) laboratory services, (e) maternal and child health, (f) public health education. A summary of the accomplishments in these fields during the year follows:

(a) Vital Statistics:

During the year 1948 birth and death registrations continued on the upward swing. In the first eleven months a total of 43,196 births and 13,287 deaths were registered.

Through newly established procedures in notification of birth registrations the demand for copies of birth certificates has increased appreciably. Through this increased demand the department issued twenty-five per cent more photostatic copies of birth certificates during 1948 than were issued in 1947.

(b) Communicable Disease Control:

Communicable Disease Control activities are carried on

by the following divisions in the State Health Department: The Division of Communicable Disease Control, the Division of Tuberculosis Control, the Division of Venereal Disease Control, the Bureau of Sanitary Engineering, and the Division of Malaria and Typhus Control.

Diseases Reported, 1948

(Median 1943-47 in parentheses)

Above Median

Chickenpox (1232)	1891
Measles (3281)	4327
Poliomyelitis (77)	146
Tularemia (102)	162
Whooping cough (935)	1267
Diphtheria (328)	156
Influenza (10043)	7795
Malaria (1349)	636
Meningococcus meningitis (127)	34
Mumps (937)	898
Scarlet fever (396)	262
Typhoid fever (141)	111
Undulant fever (47)	44

Of the diseases reported in 1948 below the 5-year median, diphtheria (156) and malaria (636) are at an all-time low from records available since 1920. Typhoid fever remains at a low prevalence although a few more cases were reported in 1948 than in 1947. A more intense epidemiological investigation of reported cases of typhoid fever resulted in the identification of eleven chronic carriers of this disease during the year. Four additional carriers notified from other states were put under carrier-quarantine. Just as the year ended an increased prevalence of influenza was reported, but no epidemic of this disease was recorded in 1948. In many counties outbreaks of a mild, short-duration, intestinal infection of undetermined origin, usually diagnosed intestinal influenza or virus diarrhea, occurred during the latter half of the year.

Tuberculosis:

The control of tuberculosis at the present time can be accomplished only by breaking the chain of spread of the disease. In this respect the Division of Tuberculosis Control of the State Health Department is carrying on a joint mass X-ray survey program in cooperation with the various tuberculosis associations and interested community groups. Individual communities are selected and an intensive effort is made to X-ray every adult 14 years of age and over in the group. The majority of such surveys have attained about 75 per cent of this goal. From July, 1947, to July, 1948, 185,204 70-mm films were made. Equipment used consisted of four mobile X-ray units and three stationary units located at the University Hospital and City Health Department in Little Rock, and the Fort Smith-Sebastian County Health Department. Clinics were held in 457 different communities from July, 1947, to July, 1948, and the X-ray units were in operation 2,845 hours, an average of 65 persons being X-rayed for every hour's operation. A provisional diagnosis of pulmonary tuberculosis was made on 800 individuals, all of whom, together with X-ray findings, were referred to their family physicians. In addition, a total of 3,141 other patients were referred to their private practitioners because of suspected tuberculosis or other non-tuberculous findings; making a grand total of 3,941 patients who have been referred to the practicing physicians for further study and a final diagnosis as a direct product of the work of this Division.

In the Central Tuberculosis Case Register a record is kept of every diagnosed case of tuberculosis. On December 31, 1948, there were 7,621 such cases known to

the State Health Department which still require medical supervision, and during this time 2,362 new cases were reported. The reporting of new cases of tuberculosis by the private physicians has increased but even so, only about one-fifth of such new cases are initially reported by the private practitioner. Great improvement in this regard is needed.

Consultation in the interpretation of 14x17 chest plates sent to this office by the local physicians was rendered on 1,863 cases from July, 1947, to July, 1948. There are now on file almost one-half million photofluorographic chest films which are available for comparison with any future chest X-ray which may be made on these patients. This is believed to be a most important and invaluable service to the practicing physicians.

Venereal Disease:

On the basis of reporting during the first eleven months, it is estimated that there will be 24,949 cases of venereal disease reported in the State of Arkansas during 1948. Of this total number 18,327 are reported cases of syphilis; gonorrhea numbers 6,113 cases; and the remaining 509 cases are the so-called minor venereal diseases which include chancroid, lymphogranuloma, and granuloma inuinale.

This represents an increase of 12 per cent in the number of reported cases over the preceding year, and it seems to indicate an increase in the spread of these diseases. It should be pointed out, however, that the intensified case-finding program conducted by the Arkansas State Board of Health in addition to improved reporting through the fine cooperation of private physicians has brought about this situation. Reporting of venereal disease by physicians has increased by almost 100 per cent over last year. The Arkansas Delta Plantation Survey which has done mass testing in twenty-two eastern and southern counties this year took a total of 85,651 blood tests. Of these approximately 11 per cent were positive and a total of 7,912 cases of syphilis were found through this method. Both the health department and private physicians are digging deep into the reservoir of latest syphilis cases which has been built up over a number of years.

A bill for an act to require pre-marriage physical examinations will be introduced in the 1949 General Assembly of Arkansas. This bill will require the medical certificate of a licensed physician to the effect that the applicant for marriage is not infected with a communicable disease. The medical certificate will be accompanied by the statement from an approved laboratory that a serologic test for syphilis was performed by the laboratory. Each applicant for marriage license will be required to present the medical certificate with the statement of the laboratory to the county clerk upon making application for a marriage license.

Malaria Control:

The Malaria Control Program during 1948 operated in forty-two counties in the state. The counties in which this program operated were those which had a death rate of five per hundred thousand or more for the period 1938 through 1942. A total of 114,686 houses were sprayed with DDT during the spring and summer. Larvicidal operations for the control of mosquito breeding was carried on with the cooperation of 18 towns. Eight hundred thousand persons were protected by this work.

Six hundred thirty-four cases of malaria were reported this year compared with 1,324 in 1947. There were 14 deaths in 1948 compared to 28 in 1947. Both cases and deaths were the lowest ever reported in the history of the state.

The program during the 1949 season will be operated in 45 counties. This is in accordance with a more recent epidemiological formula which gives approval to counties for operation where five deaths per hundred thousand occurred during the period 1938 through 1943 plus one death per hundred thousand occurring for the period 1943 through 1947.

Typhus Control:

Activities in this sphere were aimed at freeing the areas involved of rats through coordinated programs of garbage control, general environmental sanitation, rat-proofing, and rat poisoning.

Supported by continuous and community-wide cooperation, which is essential to rat control operations, 29 Arkansas cities inaugurated effective garbage control programs. One sanitary land fill project was started. Two cities operated rat-proofing programs. Three hundred eight-nine buildings were rat-proofed and rat eradication operations were conducted in 1,028 establishments. In eight other cities 72,418 red squill rat poison torpedoes were distributed.

Through the above efforts typhus fever has been reduced to six cases for 1948 compared to 19 cases in 1947 and 46 cases in 1946.

(c) Environment Sanitation:

Sanitary Engineering:

The scope of the work of the Bureau of Sanitary Engineering includes the sanitary supervision of public water supplies and sewage works, milk supplies and dairy products, malaria control, typhus control, food and drug control, approval of plans for water and sewage systems and treatment plants, swimming pools and pasteurization plants.

Routine inspections have been made of most of the public water supplies during 1948 to determine compliance with good sanitation practice. The estimated expenditure for waterworks improvements during the past year was 2,260,000. This is approximately three times the amount spent for this purpose the preceding year.

Because of excessive construction costs improvements to both water and sewerage systems have been limited almost entirely to emergency requirements. It is estimated that about \$1,000,000 has been spent on sewerage improvements, which is almost double the amount spent for this purpose during 1947.

The mobile field laboratory has been used at 20 water purification plants and eleven sewage treatment plants, staying approximately a week at each plant to determine plant efficiencies and remedying faulty operations.

Milk Control:

The Division of Milk Control has been concerned mainly with the building of new pasteurization plants and dairy barns. At the present time there are more than one hundred pasteurization plants located throughout the state leaving a very small area which does not have pasteurized milk available to the people. The percentage of pasteurized milk consumed has increased almost one hundred per cent. In several of our towns and cities all of the milk consumed is pasteurized and in the others only a very small amount of the milk is consumed raw. The dairy industry has been developed in areas of the state where previously there was none. As a result of the improvement of the quality of the milk supplies, there has been a very definite increase in per capita consumption. On the basis of statistics, there has been a reduction in the incidence of milk borne diseases. This is attributed mainly to the improvement in milk sanitation.

Food and Drug Division:

The Food and Drug Division spent the past year in

initiating a number of new programs in addition to continuing the programs that were started in 1946 and 1947. Prominent among the new projects were the inspection of the eating and drinking facilities of all the licensed hospitals in Arkansas, the holding of meetings in several counties for workers and officials of school lunch projects in order to assist in an understanding of the health requirements, and extensive work on the enforcement of the Barbiturate Act of 1937. Among the earlier programs to which a great deal of time and work was devoted may be found the improvement of sanitary conditions in canning plants, grocery stores, markets, slaughter houses, packing plants, bakeries, candy kitchens, bottling plants and restaurants. An intensive program in the improvement of sanitation in school lunch projects was carried out.

The Food and Drug Laboratory was active in the analysis of food and drug samples and the chemist assisted in the successful prosecution of a number of cases involving the selling of adulterated hamburger. During the course of inspections carried out by the Food and Drug Division, great quantities of food products that were found to be unfit for human consumption were voluntarily destroyed by the manufacturers or possessors.

Dairy Products:

During the past year the responsibility of the Dairy Products Division has increased materially by expansion of the various branches of the dairy industry which it supervises.

The Division has carried on a rigid sanitary inspection of creameries, cheese factories, condenseries, condensery depots, ice cream plants, counter freezers and cream stations. Routine examination of the raw materials and of the finished product is indicative of the industries' progress in improvement of the quality of the materials bought from the producers and the manufactured products sold to the consumers.

(d) Laboratory Services:

During the year 1948, the Hygienic Laboratory received and examined 241,705 specimens. This is an increase of 81,950 over the calendar year 1947. A large portion of this increase consists of specimens from the Delta Plantation Venereal Disease Survey. However, significant increases are noted in all branches of laboratory work.

The Serology Division of the laboratory participated in the Annual Syphilis Serology Evaluation conducted by the United States Public Health Service in order to determine the accuracy of the various serological procedures performed. The Kline test as performed in the Hygienic Laboratory was 74.9 per cent sensitive and 100 per cent specific as compared to 66.4 per cent sensitivity and 100 per cent specific when conducted by Doctor Kline himself. In the case of the Kolmer Complement Fixation test, the sensitivity was of 71.1 per cent and specificity was 100 per cent as compared to 74.4 per cent sensitivity and 100 per cent specificity of the control laboratory's test.

The lack of sufficient qualified personnel prevents such as quantitative serologic determinations, virus differentiations, and better Rickettsial procedures.

(e) Maternal and Child Health:

As a result of increased availability of trained personnel, the Maternal and Child Health Division has been able to extend services to mothers and children to a degree not possible since the beginning of the war years. A chief nutritionist, two nutrition consultants, one staff nutritionist, and a dietitian consultant were obtained and placed on duty during the year. Nutrition consultation

service is now offered to the entire state. The position of dietitian consultant is new in Arkansas—the chief duties are to advise with hospitals and other institutions concerning dietary phases of care, personnel and facilities.

A health educator with special training in hearing and vision testing was added to the staff to instruct public health nurses and selected school personnel in the use of audiometers and Massachusetts vision test equipment assigned to county health units for use chiefly in the school health program. This is done in close cooperation with a special committee of the State Medical Society.

A workshop in school health was conducted by this division and the State Department of Education. In connection with this, a permanent joint Health Education Workshop Committee has been organized and ten schools have been designated as pilot school projects in which to work out the best practical methods in school health services for Arkansas.

Through the efforts of this division as co-sponsor, a post-graduate refresher course in pediatrics was furnished 150 Arkansas physicians. Scholarships were granted 14 trainees, all employees of the Health Department. Prenatal or well-child conferences were held in 21 counties and the cities of Little Rock and North Little Rock; six of these were established in 1948.

The work of midwives was continued. In 1947 they attended 15.7 per cent of the live births in the state.

Two publications on prenatal and infant care and two sets of posters were prepared and made available to physicians and county health units.

(f) Public Health Education:

The Division of Public Health Education established in July, 1946, has made considerable progress in two years of existence.

We now have a library containing 2,460 reference volumes; a film containing 210 titles and 76 film strips.

During the past year the film library circulated a total of 1,563 films and 246 film strips. These were shown to a total audience of 108,681. More than half a million pieces of public health literature were distributed. The division participated in five summer workshops; gave consultation service to other divisions of the Arkansas State Board of Health and state voluntary agencies; published a monthly bulletin; developed a number of public health posters and pamphlets; and edited and published the Annual Report.

The Arkansas State Board of Health has now in operation two newly established divisions which have shown marked progress during the year 1948. These divisions are the Division of Hospitals and the Division of Industrial Hygiene.

The Division of Hospitals was established through the authorization of Act 85 of 1947. To date this division has inspected approximately 50 per cent of the hospitals in the state. Licenses have been granted to 165 hospital units. The benefits of Public Law 725 has provided financial aid with reference to the construction of hospitals and public health facilities in the total amount of \$3,934,627. Applications have been received and processed for eleven general hospitals, which upon completion of construction, will provide 536 additional hospital beds in the State of Arkansas, also one tubercular unit of 100-bed capacity for the State Mental Hospital, one 460-bed ward building for the State Mental Hospital and four service units for the State Mental Hospital.

The total amount of hospital construction covered by the accepted applications is \$7,682,576.52 of which ap-

proximately one-third will be provided by the federal government.

During the year 1948 the Division of Industrial Hygiene completed 393 visits to 172 industrial establishments employing approximately 40,000 employees. These visits were for the primary purpose of assisting in the improvement of the health and working conditions of the employees. Engineering, chemical and educational services were offered as follows:

1. Finding and evaluating occupational health hazards.
2. Recommendations of controlling the working environment and improving the health program and plant sanitation.
3. Educational talks, pamphlets and posters.

The response of plant management throughout the state with reference to cooperation and the establishment of recommendations made by this division strongly indicates that modern industry and plant management feels that an aggressive industrial health program within industry is a very worthwhile program. In the future, representatives of this division will make annual visits to industrial establishments throughout the state for the purpose of completing educational studies and making further recommendations to industry with the purpose of further improving health programs for industrial employees. It is sincerely felt by the Arkansas State Board of Health that preplacement and periodic physical examinations of all industrial workers is a basic need in further promoting industrial public health programs.

Conclusion:

In order for the 75 counties of the state to establish and maintain adequate local health services, certain basic permissive legislation is necessary. Two or more counties should be permitted to pool facilities and financial resources to form district or multi-county health departments. The qualified electors of the state should be permitted to vote for a two-mill tax on personal property and real estate for public health services within the county. If such permissive legislation is approved, the task of further developing adequate local public health services would be much easier and adequate coverage of the state would be much more likely. Arkansas remains only one of ten states not having in effect a premarital physical examination law to determine the existence of a communicable disease in either marital partner. Thirty-eight states now have such a law in effect. The passage of such legislation would aid materially in the prevention of syphilis in early marriage. We also have every reason to believe that this protection measure in early marriage would be a great aid in further decreasing the incidence of congenital syphilis and stillbirths due to syphilis.

It is sincerely felt by this department that with the present salary pay scales for professional and non-professional workers that the health program throughout the state cannot compete in the procurement of badly needed personnel with private industry, private institutions and federal agencies. It is sincerely felt that the State of Arkansas, as well as local units of government, should allow adequate appropriations which will permit adequate salaries for health workers, thereby eliminating the present shortage of public health workers throughout the state.

COMMITTEE ON MEDICAL ECONOMICS

HENRY G. HOLLENBERG, Chairman

The Committee on Economics and Medical Care, composed of Doctors Monfort, Sneed and Hollenberg, chairman, has held no formal meetings throughout the year. In an indirect way, however, the members of the com-

mittee chose to feel that they have had some part in numerous activities of the Society pertaining to medical economics and medical care. Prominent among these are the matters of the Blue Cross and various problems connected with the State Medical School and the proposed medical center.

COMMITTEE ON SCIENTIFIC EXHIBITS

H. KING WADE, JR., Chairman

Having had no previous experience with this type of report, I am sure that you will find this one too full for detail. However, I know that you will cut it down to size, and I do feel that some of this information may be helpful in the future.

The Committee on Scientific Exhibits contacted by letter and telephone the following organized groups:

Cooper Clinic, Fort Smith.
Johnson and Ketz Clinic, Batesville.
Harris Hospital and Clinic, Newport.
Gilbert Clinic, Little Rock.
Wade Clinic, Hot Springs.
Wilson Clinic, Magnolia.
Conway Medical Clinic, Conway.
Hawkins Clinic and Hospital, Searcy.
Robins Clinic, Camden.
Southern Clinic, Texarkana.
State T. B. Sanatorium.
University of Arkansas Medical School.
Holt-Krock Clinic, Fort Smith.
North Arkansas Clinic, Batesville.
Buchanan Clinic, Prescott.
Army-Navy General Hospital, Hot Springs.
State Hospital, Little Rock.
Daniel-Harrell Clinic, Texarkana.
Trinity Hospital, Little Rock.
Baptist State Hospital, Little Rock.

Through the individual committee members, and with the help of other doctors who were not members of the committee, an attempt was made to contact the majority of the county medical societies in the state, requesting them to give exhibits as a group, or as individuals, if so desired. The following groups are desirous of giving exhibits:

State Hospital.
Garland County Medical Society.
Daniel-Harrell Clinic.
North Arkansas Clinic.
Cooper Clinic.
Trinity Hospital.
Baptist State Hospital.
Southern Clinic.
University of Arkansas Medical School (five different exhibits).

This makes a total of thirteen planned exhibits. Most of the groups contacted responded very favorably. Many indicated an interest in this sort of thing, and many indicated that they might possibly wish to have exhibits next year.

I recommend to the Society:

1. Adequate space be provided for doctors or groups who are exhibiting.
2. That the space for such exhibits be placed in a prominent and accessible place.
3. That the presiding officer call attention to these exhibits at the opening session, and urge the general membership to give them some attention.
4. That the committee diligently follow up this work in the coming year, as, by so doing, I feel that this par-

ticular exhibit can be made into a prominent part of our medical meetings.

Supplementary to his published report, H. King Wade, Jr., chairman, requested special recognition be awarded Anderson Nettleship, co-chairman, for outstanding work on scientific exhibits. In addition, he read a letter from the Southern Clinic of Texarkana requesting the privilege of making an award to the most outstanding scientific exhibit to be decided upon by the House of Delegates.

COMMITTEE ON NECROLOGY

L. H. McDANIEL, Chairman

The Annual Memorial Services on April 15th will constitute the report of the Committee.

COMMITTEE ON CANCER CONTROL

FRED HAMES, Chairman

The Committee on Cancer Control has sponsored, and different members assisted in holding, several cancer diagnostic clinics throughout the state. These clinics are proving to be of great value, and it is worth mentioning that the incidence of cancer among those who report for examination has shown a notable decrease for the past three years.

The Committee on Professional Education has distributed literature on cancer to the profession generally.

Those members of the committee who also serve on the Board of the Field Army have given freely of their time, and have responded wholeheartedly in their efforts to increase the value of the Field Army to the public.

COMMITTEE ON MATERNAL AND CHILD WELFARE

I. F. JONES, Chairman

The Committee on Maternal and Child Welfare has not had a meeting this year. Nothing of special importance has come before the chairman that he deemed it necessary to call a meeting of the committee.

COMMITTEE ON THE HEART

E. DRIVER ROWLAND, Chairman

The main activity of the Section on Heart of the Arkansas Medical Society has been centered around the organization and development of the Arkansas State Heart Association.

This organization was conceived and the movement for its inception sponsored by Joseph T. Roberts, then Dean and head of the Medical Department of the University of Arkansas School of Medicine, and Fred Harris of Little Rock, Arkansas, following their attendance of the annual meeting of the American Heart Association in the fall of 1948. Accordingly, at the suggestion of these men, a group of some twenty physicians from various sections of the state met in Little Rock on October 17, 1948, and unanimously agreed to organize the Arkansas Heart Association.

At this meeting Joseph T. Roberts of Little Rock was elected President, Driver Rowland, Hot Springs, Vice-President, and John Greutter, Little Rock, Secretary-Treasurer. The officers were named as a temporary executive committee and authorized to submit to the Association the names of Association members for appointment to the following committees: Constitution and By-Laws, Publicity, Executive, and Program.

The first regular meeting of the Association was held in Little Rock, December 17, 1948, at which time the Constitution and By-Laws were presented and approved.

Also, the following committee appointments were approved:

1. Constitution and By-Laws Committee: Chairman, J. N. Compton, Little Rock; Owen W. Beard, University of Arkansas School of Medicine, Little Rock; Paul D. Day, Professor of Bio-Chemistry, University of Arkansas; W. C. Langston, Acting Dean, University of Arkansas School of Medicine.

2. Publicity Committee: Chairman, Fred W. Harris, Little Rock; George W. Parsons, Texarkana, Arkansas; A. A. Blair, Fort Smith; Frank Adams, Hot Springs.

3. Executive Committee: The officers of the Association and the following physicians: S. C. Fulmer, Little Rock; John N. Compton, Little Rock; S. T. W. Cull, Little Rock; Oliver C. Melson, Little Rock; Euclid Smith, Hot Springs; George W. Parsons, Texarkana, Arkansas; H. T. Smith, McGehee; A. A. Blair, Fort Smith; Charles Chamberlain, Fort Smith; Henry Hollenberg, Little Rock; D. A. Rhinehart, Little Rock; Fred W. Harris, Little Rock; L. H. McDaniel, Tyronza; Dan Autry, Little Rock; Carl Rosenbaum, Little Rock; Ralph McLochlin, Little Rock.

4. Program Committee: Daniel H. Autry, Owen W. Beard, B. P. Briggs, Isadore Meschan, Harvey Shipp.

The Arkansas Heart Association is to be patterned after and affiliated with the American Heart Association. The purpose of the Association is for the study of and dissemination of knowledge about cardiovascular diseases and related subjects.

The problem of membership in the Arkansas Heart Association has been discussed, and it was unanimously agreed that any member of the Arkansas Medical Society in good standing and who is interested in the problems peculiar to cardiovascular disease would be eligible. It was also considered that any scientist associated with any reputable institution would be deemed acceptable for membership. Lay personnel will be invited at a later date to affiliate with the organization, but this matter will be considered after acceptance of the rules stated in the Constitution and By-Laws, which are in the process of formulation at this time.

It is believed that the organization of the Arkansas Heart Association is a step forward in the advancement of the study of heart disease in Arkansas. Further proceedings and scientific articles emanating from this group are expected to be published in the Journal of the Arkansas State Medical Society, and it is expected that the activities of this association will be closely correlated with the Section on Heart of the Arkansas State Medical Society.

COMMITTEE ON POSTGRADUATE STUDY

A. D. GARNER, Chairman

On January 30, 1949, the Committee on Post-graduate Medical Education met at the Albert Pike Hotel. The chairman and four members were present (D. A. Rhinehart, Jeff Banks, Ernest Stroud and J. H. McCurry). Questions concerning an expanded post-graduate study program were discussed and the various problems to be faced and overcome were considered. It was felt by the entire committee that a more comprehensive plan of study, as presently practiced in other states, should be attempted, even though such plans call for a great deal more effort than has been possible during the immediate post-war years.

Study of the post-graduate medical training schedule of various neighboring states indicate the need for a permanent committee on post-graduate study which will be able to carry out projected plans from year to year in order to avoid the heretofore unavoidable loss of time

and change in ideas and perspective that has been the result of an almost complete change in committee personnel each year.

The possibility of asking the appointment of a permanent chairman or secretary of the committee was considered. Dr. Rhinehart recommended that in lieu of the permanent chairman or secretary that the committee ask the House of Delegates to consider the appointment of ten (10) committeemen for a five (5) year term in place of the present six (6). He further recommended that two of these committeemen be appointed co-chairmen with the proviso that the two co-chairmen be retired at the end of the year to be replaced by two more committeemen. In this manner the committee would become semi-perpetual and the two doctors with four years seniority would automatically become co-chairmen during their fifth year. This recommendation was discussed by the committee and it was agreed that such a change would be recommended to the House of Delegates for consideration at the annual meeting in April, 1949.

The advantages and disadvantages of five (5) plans for statewide medical study meetings were advanced. No satisfactory decision was reached during our discussions and it was finally decided that a letter should be written to the secretary of each county society asking him to present, at an open meeting prior to the April state meeting, the question of which type of program the doctors would prefer. The five (5) suggested plans were as follows:

1. That the Committee on Post-Graduate Medical Education furnish funds and support to the Committee on Post-Graduate Medical Study of the University of Arkansas School of Medicine, and cooperate with it in securing speakers and publicizing any meeting to be held in connection with University activities.

2. That the Committee on Post-Graduate Medical Education hold a semi-annual meeting in Little Rock, using any available funds to provide speakers and publicizing such meetings.

3. That the Committee on Post-Graduate Medical Education cooperate with the ten (10) councilor districts in planning their semi-annual meetings, providing speakers and publicity.

4. That the Committee on Post-Graduate Medical Education recommend a division of the state into five (5) districts including northwestern counties in one district, northeastern counties in a second, southeastern counties in a third, southwestern counties in a fourth, and counties in the central part of the state in a fifth district. Programs in post-graduate medical education planned and financed by the committee would be held in each of the five (5) districts every three (3) months.

5. That the committee endeavor to secure financial assistance from the Commonwealth Foundation or a similar group so as to make possible the employment of a full-time lecturer in obstetrics, pediatrics, medicine or surgery who would give complete post-graduate training courses in various sections of the state throughout the year.

The committee appreciates the difficulties to be encountered in securing the services of first class speakers for many small meetings to be held frequently in smaller centers. It also recognizes the difficulties that busy physicians face in attempting to absent themselves from their patients for several days in order to travel to a distant city for post-graduate study. Our problem is to consider the needs and wishes of the doctors themselves and to attempt to supply the best possible training to the greatest number of those who may be interested.

The committee has sponsored two post-graduate training courses during the year, both provided by the Committee on Post-Graduate Medical Education of the University of Arkansas School of Medicine. The post-graduate pediatric course was held at the University Hospital November 4 to 6, 1948, and the post-graduate course in tropical medicine was given January 20 and 21, 1949. Both meetings were well attended.

At the beginning of the year the committee had \$366.03 in the treasury. No funds have been collected or disbursed during the year.

At the conclusion of the meeting, it was agreed that the chairman write to all state organizations that might possibly supply funds to the committee so as to determine its potential assets and, further, that the Commonwealth Foundation and other similar groups should be contacted to elicit information regarding the possibility of our securing funds to help out in an expended post-graduate medical training program. A second meeting to be held early in April will be called to consider any information that may be received during the next two months.

The recommendation of the committee is as follows:

That ten (10) doctors be appointed as the Committee on Post-Graduate Medical Education, two for one year, two for two years, two for three years, two for four years and two for five years. That two doctors be retired from the committee each year to be replaced by two new appointees who would be appointed to serve five years. In this manner the committee would become a more permanent organization which could work out the long-term plan for post-graduate study best suited to the needs and wishes of the doctors throughout the state.

COMMITTEE ON THE AUXILIARY TO THE ARKANSAS MEDICAL SOCIETY

LOUIS K. HUNDLEY, Chairman

The Auxiliary in 1948-49, under the leadership of Mrs. Mason G. Lawson, has had a most active and profitable year. Much progress has been made in enlarging both the membership and scope of this organization. The Auxiliary is to be highly commended for its very complete educational program, with particular reference to national policies and legislation. Their aim has been to acquaint each Auxiliary member with all legislation which might affect the practice of medicine; to inform themselves in such a way that they can, by both individual conversation and by public speeches, and articles, help educate the public on medical affairs.

Mrs. Lawson's report gives all details of the activities of the Auxiliary and is most complete. I would like to call attention to the call meeting of the Auxiliary board for the purpose of hearing Dr. Clay Chenault explain the Medical School's plan for the new Medical Center. This meeting was held at our request and was well attended. The Board voted unanimously to support the Medical Center plan.

Attention is called to the large amount of travel which is necessary for the President of the Auxiliary as well as the President-elect. At present the President has a travel allowance of \$100 a year and the President-elect none. (This is financed by the Auxiliary.) It is felt that the Society should help the Auxiliary by giving them an increased allowance for this purpose.

It is obvious that our Auxiliary is ready, willing and fully capable of doing a great deal more to help our Society than they have been allowed to do in the past. After studying the program in other states, in which the

Auxiliaries are encouraged to carry on an intensive Public Relations Program for the Society, I am convinced we have neglected to use to full advantage one of our greatest assets—an intelligent, enthusiastic, well organized Auxiliary.

Recommendations:

1. That the President of the Woman's Auxiliary be allowed a place at all Council Meetings, without vote, for the purpose of keeping her completely informed on the policies and activities of the Medical Society.
2. An allowance of \$500 for the President and \$100 for the President-elect of the Auxiliary, for reimbursement for travel expenses.
3. Payment of dues for membership in Arkansas Legislative Council.
4. Appropriation of the usual fund for publishing minutes of the state meeting.
5. Designation of one member of each County Society as advisor to that Society's Auxiliary.

REPORT OF THE PRESIDENT OF THE WOMAN'S AUXILIARY TO THE ARKANSAS MEDICAL SOCIETY TO THE CHAIRMAN OF THE ADVISORY BOARD

As President of the Woman's Auxiliary to the Arkansas Medical Society I have endeavored to follow the general outline of the Woman's Auxiliary to the American Medical Association and adapt it to fit our local needs in Arkansas. We have emphasized public relations, legislation, both state and national, a larger and more informed membership, the organization of new Auxiliaries wherever possible and the securing of members-at-large in counties where no organization is possible. We have urged County Auxiliaries to place Hygeia subscriptions in local and rural schools. This has worked well and has been well received by the teachers in these schools. Each member has been urged to have a complete physical examination once each year. Every Auxiliary is expected to observe Doctor's Day in March to honor local doctors. Some will have editorials in their local papers, the ministers of the various churches will make comments about the value of the physician to their community so that the laity may also become more conscious of their doctor's services.

Much emphasis has been placed on legislation. Our members have been urged to listen to radio broadcasts, read the newspapers and periodicals, so that they may be aware at all times of pending legislation concerning the medical profession. They have been instructed to become well informed so that they may interpret correctly to the public any proposal affecting their health and general welfare.

We have cooperated with the Medical Society in informing the public of a need for a Medical Center. Each member of the Auxiliary was asked to contact the legislators in their district, informing them of their desire that a complete Medical Center be established.

Each County Auxiliary has been urged to take an active interest in local civic affairs. We have insisted that our members as individuals actively engage in any local project which may be of value to her community, such as Health Chairman of local clubs, cooperation with local hospitals, etc.

One new committee was organized at the Post-Convention Board meeting. The Martha Harding Gann Memorial Loan Fund for student nurses was given \$1,500 by Dr. Dewell Gann, Jr., of Benton, in memory of his mother who was the second President of the State Auxiliary. This fund was incorporated, with the permission of the Medical Society. It is now a non-profit organization and tax exempt. We have one loan out at present with sev-

eral prospects of other loans in the near future. Mrs. Curtis W. Jones of Benton was made permanent chairman of this fund at the request of Dr. Gann.

The Ilse F. Oates Student Loan Fund for medical students has been increased substantially by contributions from County Auxiliaries. We have at present one loan out and, in all, 74 loans have been made since the fund has been active.

Through the cooperation of Mrs. W. R. Brooksher, Pulaski County will have a national speaker from the American Field Army, Mrs. David S. Long, who will speak on Cancer Control. Arrangements have also been made for Mrs. Long to speak before the Women of the Churches.

Mrs. C. W. Dixon has completed twelve biographies, and they are now ready for publication in the space allotted to the Auxiliary by the Arkansas Journal.

We are cooperating with the Auxiliary to the Southern Medical Association in creating a committee on research. The County Auxiliaries have been asked to send in any outstanding paper or talk by Auxiliary member or members of the medical societies so that they may be incorporated in the files of the Romance and Research Committee of the Southern Auxiliary.

The Earle Chambers Memorial Library Fund sponsored by the Auxiliary is used for the three state sanatoria to add new books to their libraries. We hope to have approximately eight hundred dollars (\$800) in the fund by April 15, 1949.

County Activities

Jefferson County has chosen as a project for the year the redecoration and furnishing of a room in the Pine Bluff hospital.

Union County has established a nursing scholarship in the Warner Brown Hospital. They also assisted in the Warren disaster by sending a contribution of clothes.

Craighead-Poinsett Counties expect to buy a light wheelchair for use in the local hospital.

Garland County has placed Hygeia in all county schools.

Hempstead County is working on nursing recruitment.

Sevier County has made contributions to all of the Auxiliary Loan Funds and has also placed Hygeia in the schools. A contribution has been made to the library fund.

Pulaski County expects to contribute approximately two hundred fifty dollars (\$250) to the Ilse F. Oates Student Loan Fund. They have established a committee on Nursing Relations to provide recreation for student nurses in the local hospitals. They have "adopted" a student nurse who is training in Baptist Hospital with funds from the State Auxiliary Nurses Loan Fund. She has been entertained in the homes of the committee and was given a gift when she was capped and at Christmas. This Auxiliary sponsors the Medical Dames, wives of medical students in the University of Arkansas School of Medicine. There are 55 Dames who will be future Auxiliary members and the Auxiliary feels that when these girls go back to their home counties they will be a valuable addition to their local Auxiliaries.

This is an incomplete report on county activities as reports are not yet due.

Personal Activities

Board Meetings

April 16, 1948—Post-Convention School of Instruction for Board members.

October 18, 1948—Fall Board Meeting—Reports of

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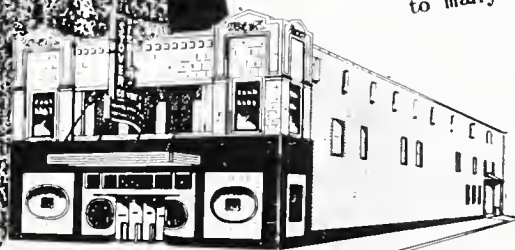
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Very sincerely yours,
THE CENTRAL PHARMACAL COMPANY
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J. L. Rogers, President



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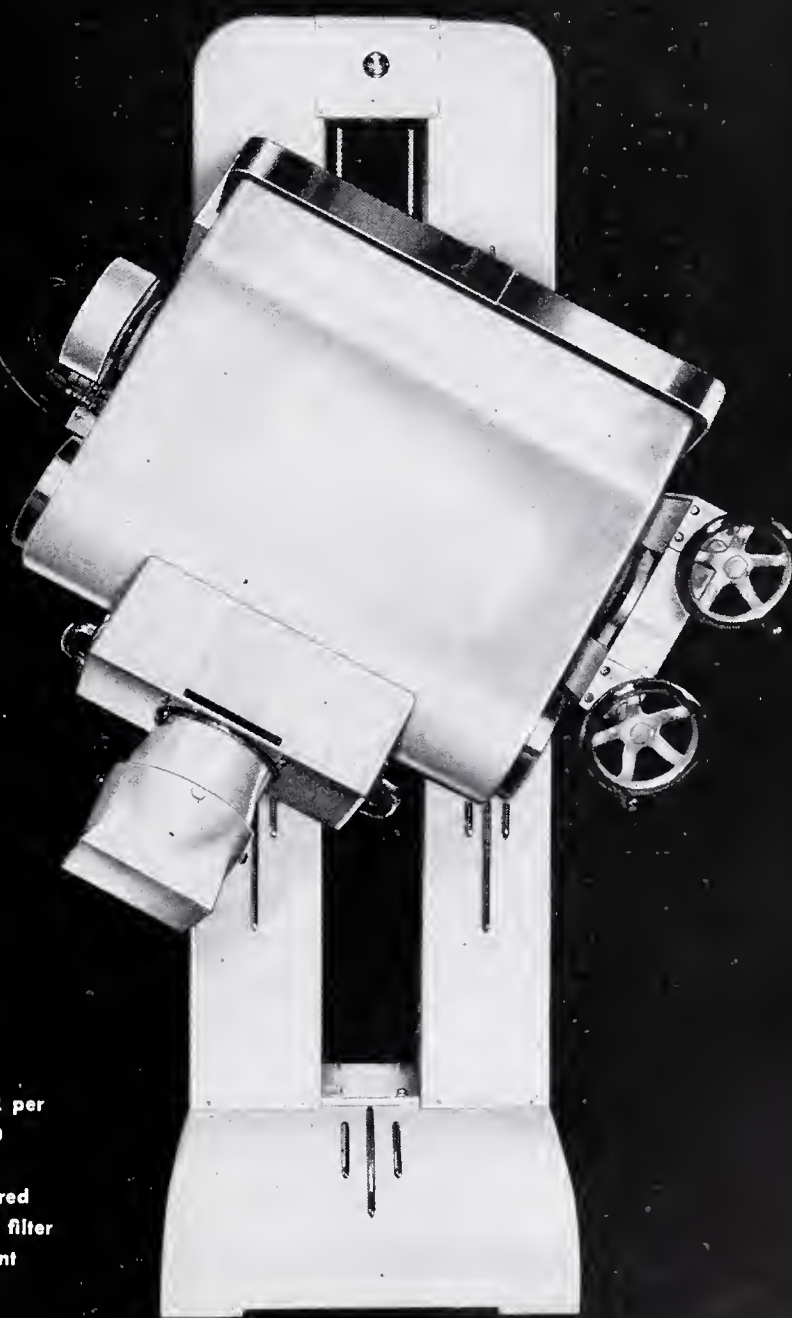
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Officers, Committee Chairmen, and County Presidents. Election of nominating committee

December 8, 1948—Called to discuss proposed Medical Center. Dr. Louis K. Hundley, chairman of the Advisory Board, and Dr. Clay Chenault, Vice-President, in charge of Medical Education of the University of Arkansas, explained the proposal.

January 28, 1948—Mid-Winter Board Meeting. Report of Nominating Committee. President—Mrs. Louis K. Hundley, Pine Bluff. President-elect—Mrs. Warren S. Riley, El Dorado. First Vice-President—Mrs. P. W. Lutterloh, Jonesboro. Third Vice-President—Mrs. J. P. Price, Monticello. Third Vice-President—Mrs. J. G. Martindale, Hope. Fourth Vice-President—Mrs. J. K. Donaldson, Little Rock. Treasurer—Mrs. V. T. Webb, Little Rock. Publicity Secretary—Mrs. Joe Verser, Harrisburg. Historian—Mrs. C. W. Garrison, Little Rock. Parliamentarian—Mrs. Martin Hawkins, Searcy. Poet Laureate—Mrs. George B. Fletcher, Hot Springs. Mrs. Hundley has named Mrs. Howard Stern of Pine Bluff as Secretary.

April 14, 1949—Pre-Convention Board Meeting.

Auxiliaries Visited to Date

May 6 and 7, 1948—Organized a new Auxiliary in Greene-Clay Counties. Mrs. Charles R. Henry, Mrs. Louis K. Hundley, Mrs. P. W. Lutterloh, and Mrs. Joe Verser assisted. Visited Craighead-Poinsett Auxiliary.

June 4, 1948—Visited Ninth Councilor District in Harrison.

June 21 to 25, 1948—Attended Auxiliary to the American Medical Association in Chicago. Five delegates were present—Mrs. Joe Verser, Harrisburg; Mrs. Ross Fowler, Harrison; Mrs. L. J. Kosminsky, Texarkana; Mrs. L. H. McDaniel, Tyronza; Mrs. D. A. Rhinehart, Little Rock.

September 14, 1948—Jefferson County at Pine Bluff.

October 22, 1948—Bowie-Miller at Texarkana, accompanied by Mrs. C. W. Garrison.

November 4 and 5, 1948—Attended fifth annual conference for Presidents and Presidents-elect in Chicago.

December 1, 1948—Accompanied Mrs. Charles R. Henry, First Vice-President, and Mrs. Louis K. Hundley, President-elect, to El Dorado. Mrs. Henry spoke on legislation.

January 7, 1949—Pine Bluff with Mrs. Charles R. Henry for a program on legislation.

January 17, 1949—Garland County at Hot Springs, accompanied by Mrs. Charles R. Henry.

February 2, 1949—Union County at El Dorado.

February 3, 1949—Columbia County at Magnolia.

February 4, 1949—Hempstead County at Hope.

February 5, 1949—Howard County at Nashville to discuss organization with Sevier County.

February 8, 1949—Sevier County at DeQueen.

February 16, 1949—Pulaski County at Little Rock.

March 14, 1949—Sebastian County at Fort Smith.

State Convention

General Chairman—Mrs. J. K. Donaldson, Little Rock.

All committees have been selected and the entire program planned. Mrs. Luther H. Kice, President of the Woman's Auxiliary to the American Medical Association, will be a guest and the speaker at a luncheon meeting on April 15th. Mrs. Joseph W. Kelso, President of the Woman's Auxiliary to the Southern Medical Society, will also be a guest along with Mrs. Neil Woodward, President of the Woman's Auxiliary to the Oklahoma State Medical Association. Mrs. Kelso will be the luncheon speaker on April 14th.

My sincere thanks for your cooperation and interest

throughout the year. It has been a great pleasure and privilege to work under your direction.

(MRS. MASON G.) MONA LAWSON.

COMMITTEE ON LIAISON WITH THE ARKANSAS TUBERCULOSIS ASSOCIATION

*A. C. SHIPP, Chairman

The Arkansas Tuberculosis Association will continue to maintain its close cooperation with various other community agencies both volunteer and public. We shall continue to stress our Cooperative Program with the State Health Department, the Division of Tuberculosis Control and the County and City Health Departments.

It is impossible to make a distinction between our program of cooperative case finding, clinics and rehabilitation, since they are so closely tied together. The success of any program, we believe, depends in large measure on the decree of cooperation between the various agencies and individuals.

Jefferson County, with 60 per cent of its population Negro, has had a very heavy tuberculosis case load. The County Medical Society became much interested in the seriousness of the problem and asked the local Tuberculosis Association to consider ways and means of getting established a Weekly Chest Clinic, which would provide some supervision for the large number of patients on leave from the Sanatorium or who were on the list waiting admission.

Several preliminary conferences with interested groups were held and two general meetings at which the entire group voted to support the clinic for at least a five-year demonstration period. Present at the meetings and participating in the discussions were the County Judge, the Mayor, committee from County Medical Society, superintendent of the local hospital, State Health Department, County Health Department, County Tuberculosis Association, State Division of Tuberculosis Control and the State Tuberculosis Association. Out of these several conferences has grown a well and carefully planned set-up for chest clinics with some financial support or assistance by all the agencies represented at the conferences.

As a guide for setting up the clinic, "The Chest Clinic Manual" presented by the National Committee on Clinic Procedure, was followed. We believe that this clinic is a splendid example of good, wholesome, county-wide support and we hope that it will be possible to have similar clinics operating in other sections of the state. From the standpoint of the tuberculous patient, the lack of clinic facilities is one of the weakest spots in the whole Tuberculosis Control Program.

We have held membership in the State Legislative Council and also the Arkansas Public Health Association. We have assisted in every way possible to further extend and develop the State Health Program and to aid in the promulgation and enforcement of much needed basic health laws. Some of these are:

(a) Law requiring pre-marital examination.

(b) Changes in Public Welfare Law.

(c) Strengthen the Division of Mental Hygiene in the State Health Department.

(d) Separate institution for care of mentally retarded children.

(e) Passage of legislation which will provide full time Health Units in each county of the state.

The Association gave support to securing from the last

*Deceased.

Legislature an appropriation to build a unit for the tuberculous insane. The contract for this building has been awarded and construction has been started on the grounds of the State Hospital in Little Rock. This will provide facilities for students from the Medical School to get valuable experience in tuberculosis and mental diseases. The Board of the Hospital is to be commended on its stand that the building should be located in Little Rock because of more adequate medical services, and Arkansas will be the second state in the United States to provide a separate unit for its tuberculous insane.

J. D. Riley, acting-chairman, paid tribute to A. C. Shipp, chairman, deceased, and spoke briefly on aspects of the State Sanatorium.

COMMITTEE ON INDUSTRIAL HEALTH

EWING M. NIXON, Chairman

One request was made of the committee by Mr. Roland Byrd, State Capitol, Little Rock, Arkansas, for a report of doctors who would be interested in treating the toxic manifestations to the chlorinated halogens, an attempt was made to select those doctors in the industrial areas of the State of Arkansas in which industries using the above compounds were located. The list is voluminous and is on file with Mr. Byrd.

The committee was not called upon to meet in full session, and as a recommendation, it is suggested that the committee meet during the annual meeting of the Society for consideration of any and all subjects pertaining to it.

COMMITTEE ON MENTAL HYGIENE

GEORGE W. JACKSON, Chairman

The problem of prevention and treatment of emotional reactions and mental illness is one of the greatest at present facing the medical profession. The importance of this group is emphasized by noting their high incidence in the general population. Well informed internists have estimated that from 30 per cent to 70 per cent of patients seeing physicians for any cause come to them with functional complaints, or complaints for which no organic basis can be found. Others state that one-third of the cases are entirely psychogenic; one-third psychogenic plus organic condition, and one-third organic.

During the past war more than one-half of all rejections from military service were for psychiatric disorders. Of those men accepted for military service and later rejected, more than one-half were also for psychiatric conditions.

From surveys which have been made of mental illness, it is estimated that five per cent of the population are either at present receiving treatment for conditions requiring hospitalization in mental hospitals, or will be confined in such institutions at some time during their lifetime.

Recently a survey of the mental health problems in Arkansas was begun. This survey is being made as a cooperative undertaking of the Arkansas State Hospital, the Arkansas Department of Public Health, and the Institute of Science and Technology of the University of Arkansas. This survey to date reveals the following facts: There were 4,768 persons in the Arkansas State Hospital on January 19, 1949. This means that about 25 persons out of every 10,000 in the state were in the mental hospital on that date. It is not known how many more cases in the state are in need of hospitalization. But it is probable that there are many since the proportion of the

total population in mental hospitals is lower for Arkansas than for about two-thirds of the other states. The actual number of persons in need of psychiatric hospitalization and other types of psychiatric treatment will be better known after the completion of the survey now in progress.

The average number of new admissions to the State Hospital between 1930 and 1944 was 1,609 each year, making a total of 24,135 citizens of Arkansas who received treatment in the State Hospital during the fifteen-year period. During the period 1940-1944 an average of over eight persons from every 10,000 citizens of the state entered the State Hospital each year.

The magnitude of the task of the State Hospital can be shown by comparison with other hospital facilities of the state: It has almost one-half of all the hospital beds in the state. It has one-third more beds than all the general hospitals in the state and renders twice as many patient-days of service, though the number of patients it treats is small in comparison. There were 4,779 men and 3,264 women admitted for the first time to the State Hospital in the period of 1940-1944. The rate of first admissions rises almost continuously, from childhood to old age. During the period of 1940-1944 the rate increased from less than one per 10,000 children under ten years of age, to 32 per 10,000 adults seventy and over.

Since the State Hospital is the largest mental institution in the state, a report of some of the increased activities is considered advisable to explain improvements resulting from the increased appropriation made possible by the Legislature in 1947: The appropriation per day per patient during the period 1947 to 1949 amounts to approximately \$1.28. This was an increase of approximately 86 cents over the previous period. The ward attendants have been placed on three shifts of eight hours each, resulting in much better care for the patients. Gradually enough doctors have been employed to enable the institution to now provide one doctor in charge of each hospital building. The use of mechanical restraints are now used only occasionally and of a very limited extent. Untidy wards have been gradually eliminated by better attention and training of patients and improved care from the attendants and supervising medical staff. A program of attendant training has been instituted under the supervision of a Director of Nurses and an assistant nurse. Lectures and practical demonstrations in the care and treatment of the mentally ill and physically sick patients have resulted in a healthier attitude toward the hospital by both the attendants and the patients. Where previously no records were being kept on the wards, there is now gradually being instituted a system whereby each patient has a ward chart which includes a medication sheet on which all medications and treatments are recorded, progress sheet, and a clothing record—all orders by the medical staff being recorded in a doctor's order book. Children confined in the institution who, for the most part, are mentally deficient have now been moved to one building and a full-time teacher and assistant are now in charge of the training and education of these individuals. This work is progressing satisfactorily with considerable enthusiasm on the part of the children and the supervising staff.

The treatment of the physically ill patients has been expanded by an arrangement with the University of Arkansas School of Medicine. The Medical School furnishes two medical residents, one surgical resident, and a resident in pathology who rotate every six months. These residents are under the supervision of the medical staff of the Medical School and the staff members visit the hospital several times weekly furnishing consulting service

in medicine, surgery, orthopedics, obstetrics, gynecology, and pathology.

The recreational and occupational facilities have been increased. At the present time movies are being shown to the patients twice weekly, both white and colored, and there is also a weekly dance for each group. Interested lay organizations provide special parties for the patients at frequent intervals. During 1948 the occupational therapy department furnished therapy to 2,593 patients. The special treatment department of the hospital has been greatly expanded so that a much larger number of patients are now receiving specific therapy. On December 15, 1948, 270 patients were receiving electroshock therapy and during the year a total of 891 patients were treated, receiving a total of 10,034 electroshock treatments. Sixty-eight patients were receiving insulin shock treatment in December. The hydrotherapy department treated 1,270 patients with a total of 49,929 treatments in 1948. This included continuous tub baths, steam cabinets and sedative packs. A total of 208 major operations were performed on patients during 1948. There were 22,482 patients and 780 employees X-rayed on regular size films; in addition, 2,731 35-mm chest films were made on patients and employees. The results of the extended medical services can best be emphasized by quoting some statistics: In 1945, 1,961 patients were admitted to this hospital and 1,048 patients were discharged. In 1947, 2,050 patients were admitted and 1,519 were discharged. The death rate among hospital patients has been reduced from a total of 601 in 1945 to 379 for the eleven months' period through November, 1948.

Many improvements have been made in the physical plant but will not be included in this report. The Legislature appropriated \$2,000,000 for construction during the two-year period. This amount was not adequate to carry out the construction as outlined by the Legislature. It was possible to obtain approximately \$1,000,000 in federal matching funds to supplement the appropriation and all units are now under contract. The units include an addition to the laundry at Benton; a new cold storage and cannery at the Benton unit; a 400-bed ward and 60-bed infirmary at the Benton unit; a new laundry at the Little Rock unit; a new cold storage at Little Rock, and a 100-bed tubercular building at the Little Rock unit.

Adequate treatment in our state mental institutions alone is not adequate to solve the mental health program of the state. The early detection and prevention of mental illness are necessary, as well as an adequate training program to fulfill the statewide needs of personnel. Much has been done during the past year by many organizations throughout the state and much is being done at present which merits the full cooperation of the Medical Society. The State Mental Hygiene Society recently formed in the state will render a great service in the education of the public and in stimulating the necessary assistance in carrying out the programs initiated. The Council on Children and Youth during the past year made a survey of the mentally retarded in the state and found that there were approximately 5,000 mentally retarded children within the state between the ages of four and eighteen years. These individuals are unable to receive proper training in the regular public school program. Of this number, 4,500 could be trained in the public school system if special classes were provided. Five hundred would require training in an institution. The Council recommends the establishment of a special unit for the training of these children, to be located near one of the state teachers' colleges. This would make pos-

sible the adequate training of this group of children, as well as make possible special classes of instruction for the training of the necessary teachers to supply the needs.

An effort is being made at present to relocate the Arkansas School of Medicine and Memorial Hospital on the hospital grounds of the State Hospital. The relocation of the Medical School on the hospital grounds would make possible expansion of the present four-year program in psychiatry for medical students, increased facilities for the training of residents in psychiatry, as well as residents in other specialties in the treatment of mental disorders.

Federal funds received through the State Health Department during the past year have made possible the establishment of a mental hygiene clinic at the University of Arkansas School of Medicine and this clinic can now receive patients referred for examination and treatment on an out-patient basis. This clinic is of course accessible to only a limited number of people but is a step forward and the first of many such clinics which should be established throughout the state.

The number of elderly mentally ill people has greatly increased during the past few years and at present there are approximately thirty cases per month admitted to the State Hospital. The problem of the treatment of this group should receive considerable attention. The life expectancy is increasing from year to year and it can be expected that this group will greatly increase during the next few years.

In a report of this nature, it is impossible to go into detail and adequately cover the field of mental hygiene within our state.

In conclusion, mention should be made of the needs of providing psychiatric service to our penal institutions and correctional institutions, as well as service to the various courts over the state.

Recommendations of the committee are as follows:

1. The society as a whole should endorse and support the State Mental Hygiene Society.
2. The establishment of a separate institution near one of the teachers' training colleges in the state for the retarded children requiring institutional care.
3. The establishment of a separate institution for the non-psychotic epileptics.
4. Recommends the establishment of the Medical Center on the State Hospital grounds, as the committee considers this a forward step in the treatment of the mentally ill.
5. That a competent and qualified psychiatric service be provided the penal and correctional institutions of the state. This service to be furnished by the Bureau of Mental Hygiene of the State Health Department.
6. The Society aid in making available beds in general and regional hospitals for the examination and treatment of the mentally ill.

COMMITTEE ON EMERGENCY MEDICAL CARE

ROY I. MILLARD, Chairman

The committee has divided the state into five groups of fifteen counties each, with one member of the committee responsible for the organization of a county set-up for Civilian Defense. It is our plan to form the framework of Civilian Defense according to the National Office of Civilian Defense. The committee has secured the cooperation of the Governor and it is expected that a complete set-up on a city and county basis will be established before the state meeting in April.

Roy I. Millard, chairman, reported on the meeting on

March 21, 1949, of the Council on National Emergency Medical Service of the American Medical Association, paying special tribute to the Council's Disaster Committee and its organization at the present time.

COMMITTEE ON RURAL HEALTH

JOE W. REID, Chairman

The one project of the Committee on Rural Health this year is a Health Conference to be held in April. The University of Arkansas Extension Department, with leaders of various farm groups, are very enthusiastic about such a meeting. This meeting will enable the farmer and the physician to formulate plans and to discuss and solve our own health problems among ourselves.

JOINT COMMITTEE OF THE ARKANSAS MEDICAL SOCIETY AND THE ARKANSAS HOSPITAL ASSOCIATION

CHARLES R. HENRY, Chairman

(Read by Ellery C. Gay)

We, the members of the Joint Committee appointed by Dr. King Wade in April, 1946, have completed the task assigned to us in the following manner:

Organization and operation of a voluntary prepaid health insurance program using a commercial carrier. This proved unsatisfactory and the program was discontinued, and our approval of such, withdrawn.

Under authority of the meeting of the House of Delegates of October 10, 1948, in Little Rock, the recommendation of the Joint Committee was approved as follows:

That the Blue Cross-Blue Shield program be established and put into operation as soon as possible.

Funds were made available through the Arkansas Medical Society, Arkansas Hospital Association and the Arkansas Farm Bureau and the plan was put into effect January 1, 1949.

This Committee now feels that its function has been completed.

We move the adoption of the following resolution and dissolution of the Committee:

"Whereas, the Committee has fulfilled the mandate given it by the Society,

"And whereas, a Blue Cross-Blue Shield Voluntary Non-profit Surgical and Hospital Plan is now in successful operation,

"And whereas, this plan has been given approval by the American Medical Association and the American Hospital Association,

"Be it resolved that the Arkansas Medical Society approve the Arkansas Medical and Hospital Service, Incorporated.

"And be it resolved, that all county societies of the Arkansas Medical Society adopt a resolution approving the Arkansas Medical and Hospital Service, Incorporated, as the officially sponsored plan."

Following the report, Ellery Gay read a letter from Mr. John A. Rowland, Secretary, Arkansas Medical and Hospital Service, Inc., stating that Dr. R. C. Dickinson, Horatio, had been nominated by the corporation's nominating committee to succeed himself for a term of six years expiring in 1955, and that H. T. Smith, McGehee, had been nominated to fill the vacancy created by the resignation of Roy I. Millard, Russellville, the term to expire in 1954.

COMMITTEE FOR THE EXTENSION OF MEDICAL CARE

CHARLES R. HENRY, Chairman

(Read by George Steinkamp)

In Chicago, February 12, 1949, the American Medical Association held a conference of State Medical Societies. Attending this meeting from Arkansas were:

R. B. Robins, Camden, member of the Coordinating Committee of the AMA's National Educational Campaign; D. A. Rhinehart, Little Rock, representative from Arkansas on the Committee of 53 (the National Committee of Representatives from each of the states and territories); Charles R. Henry, Little Rock, chairman of the Public Relations Committee; and Mr. Sid Wrightsman, Jr., Executive Secretary of the Arkansas Medical Society.

On Sunday, February 27, in Little Rock, at 1:00 p. m., a meeting was called to which were invited the President and Secretary of each county society, the Councillors, the Public Relations Committee of the Arkansas Medical Society and representatives of the Woman's Auxiliary. Approximately 85 persons heard a report of the meeting in Chicago, the National Campaign Plan of Procedure, the problems before us, the need for urgency of action, and a plan to be executed at state level.

Following this meeting, the Committee for Extension of Medical Care was organized. Charles R. Henry was appointed chairman. The committee is composed of one leader from each Councillor district, as follows:

First: Joe Verser.

Second: J. J. Monfort.

Third: T. S. Van Duyn.

Fourth: H. W. Thomas.

Fifth: J. B. Whorton, Jr.

Sixth: Fred Ferguson.

Seventh: Joe W. Reid.

Eighth: Frank Kumpuris and George Steinkamp.

Ninth: Ulys Jackson.

Tenth: G. R. Siegel.

Mrs. Mason G. Lawson and Mrs. Louis Hundley, representing the Woman's Auxiliary.

D. A. Rhinehart.

Councillors of the Arkansas Medical Society are members ex-officio.

Meetings have been held in Little Rock on March 6th, 20th, and April 3rd.

The Committee requested the Pulaski County Medical Society to cancel its customary Thursday evening party so that an open meeting could be held as a public service activity of the State Society. Marjorie Shearon, legislative analyst of Washington, D. C., and Cecil Palmer, British author and publisher, were invited to speak.

The Committee has discussed and worked on the following projects:

A. Organization of District and County Units.

B. Organization of the Woman's Auxiliary.

C. The A.M.A. assessment.

D. The Blue Cross-Blue Shield Plan.

E. The Public Meeting.

F. Methods of raising funds at county level.

G. Advertising.

H. Methods of stimulating activity where interest is lacking.

Up to the present time, we have activity in approximately 50 per cent of our Councillor districts. In those areas where organization is going forward, we can feel justly proud of those leaders. By the same token it is disheartening to note lack of interest in the remaining

areas. It is obvious that those leaders fail to realize the seriousness and urgency of defeating compulsory health insurance.

The Woman's Auxiliary under the leadership of Mrs. Mason G. Lawson is doing a magnificent job in this campaign. Dormant auxiliaries have been reactivated. New members have been recruited and the ladies are becoming informed on the subject of socialized medicine. The Auxiliary is active in writing letters, enlisting aid of women's clubs, filling speaking engagements, getting resolutions from women's clubs and cooperating whole-heartedly with the Committee's work.

Recently the Pulaski County Medical Society assessed its members \$25 to carry on its part of the public relations program in this area of the state. One member stated that he would not pay it because committeemen would use their positions of appearing before the public for personal advantage.

I tell you, your Committees for the Extension of Medical Care are working committees and not glory committees. We know that doctors are on the spot and until it is generally realized that this is a battle for the survival of a free way of life and not a parade for personal glory, our efforts will be in vain.

We must have unity in our own ranks. We can defeat our enemies but it is difficult to fight our friends.

Those who have given so generously of their time know that we are just beginning this fight at the grass roots. This campaign must be carried on until this problem is resolved and that may be several years.

Projects in the future include a statewide program beamed to the P.T.A. and educators; church groups; a State Speakers Bureau; sponsored essay contests; radio, newspaper, advertising media; community health councils, etc. Such organization requires the direction of someone trained in the techniques of public relations and who can devote full time to this work.

As chairman of the Committee for Extension of Medical Care, I respectfully urge you to give consideration to the employing of a full-time Director of Public Relations so that a real organization can be effected.

SPECIAL COMMITTEE TO STUDY COMMITTEE ORGANIZATION

ELLERY C. GAY, Chairman

Authority: This committee was appointed by the President, P. W. Lutterloh, at the Annual Session, 1948. The following recommendations are also given with the approval of the incoming President, Euclid Smith.

Committee Report: The committee recommends that this report be accepted and the following committees placed in action for a two-year period. At the end of this trial period, if the arrangement is satisfactory, a resolution will be prepared for a necessary change in the Constitution and By-Laws to make this arrangement permanent.

A chairman shall be appointed to head each major committee. Each major committee shall have assigned to it a Vice-President who shall serve as a liaison officer to the President. It shall also be the duty of each Vice-President to see that the committees assigned to him have their annual reports prepared sixty days prior to the Annual Meeting. Specific recommendations made by each committee shall be enumerated in a final paragraph of the committee report for review by the Reference Committee at the annual session.

Chapter VIII—Committees

Section I. The standing committees of this Society shall be as follows:

A. Committee on the Annual Session

1. Program Committee
2. Scientific Exhibit Committee

(Note: These committees shall be directly responsible to the President and will work under his direction.)

B. Committee on Medical Legislation and Legal Medicine

1. Medical Legislation Committee
2. Legal Medicine Committee

C. Committee on Medical Service

1. Medical Service Committee
2. Military Medicine Committee
3. Veterans Administration Committee
4. Industrial Health Committee
5. Mental Hygiene Committee
6. Public Health Committee

D. Committee on Public Relations

1. Planning Committee
2. Speaker's Bureau Committee

E. Committee on Medical Education and Hospitals

1. Post-graduate Study Committee
2. Cancer Control Committee
3. Tuberculosis Committee
4. Maternal and Child Welfare Committee
5. Committee for Liaison with the City Health Department
6. Committee for Liaison with the State Hospital for Nervous Diseases
7. Committee on the State Medical Board of the Arkansas Medical Society

REPORT OF THE STATE MEDICAL BOARD OF THE ARKANSAS MEDICAL SOCIETY

L. J. KOSMINSKY, Secretary-Treasurer

(Read by the Secretary)

I submit herewith for your approval the report of the State Medical Board of the Arkansas Medical Society.

The Board met on the two regular meeting dates prescribed by law in June and November for examination.

Fifty-nine applicants, after having produced satisfactory evidence of having graduated from a reputable medical school and certificates from the Arkansas Basic Science Board, were examined and issued license to practice medicine and surgery in this state.

Twenty-seven students from the University of Arkansas School of Medicine were examined in the primary subjects.

After having presented satisfactory evidence of graduation from reputable medical schools, and having complied with all the necessary requirements of the law, 59 applicants from various states and the National Board of Medical Examiners were licensed to practice in this state by reciprocity and endorsement.

Duplicate license was issued to one doctor who presented evidence that his original license had been destroyed by fire.

Fifty-six licentiates of this Board were certified to various other states after submitting the necessary certification fee.

At the annual meeting of the Arkansas Medical Society last year, the Reference Committee recommended that the Secretary of the State Medical Board of the Arkansas Medical Society be bonded, and also that a certified public accountant audit the books of the Board.

In compliance with the above recommendation, the Secretary was bonded for \$10,000 and the books were audited by a certified public accountant after the close of the fiscal year in June, 1948. A copy of the auditor's

report was turned over to the Council of the Arkansas Medical Society.

Five members of the Board attended the meeting of the Federation of State Medical Boards in Chicago in February.

REPORT OF THE ARKANSAS STATE CANCER COMMISSION

CARL A. ROSENBAUM, Secretary

In its fourth year, the Arkansas Cancer Control Commission can point to tangible evidences of progress. Established by Act 277 of the 1945 General Assembly as the official agency in Arkansas responsible for the Cancer Control program, the course has been chartered toward providing diagnostic and treatment services for the medically indigent, statistical services and case-finding, coupled with educational activities.

Seven Designated Tumor Clinics

Set forth as our first objective has been the establishment and conducting of permanent tumor clinics, designated by the Commission as being qualified for and as having adequate facilities for the diagnosis and treatment of cancer. Since the Commission's last report before this House of Delegates, three new Tumor Clinics have been added to the list, namely, those at El Dorado and Jonesboro, which began formal operation during last summer, and one at St. Vincent's Infirmary, which became the second tumor clinic in Little Rock, last fall. The Tumor Clinic directors and basic and consultant staffs were selected from membership in the Medical Societies in the respective counties of the clinic. Financial aid came from the Commission to purchase clinical and office equipment and to provide a full or part-time Tumor Clinic Secretary as required. As you know, this is the pattern followed by the Commission in its relationship with its designated Tumor Clinics, now totaling seven.

American College of Surgeons approval for each of the Commission's designated Tumor Clinics is our objective. Those at University Hospital, Little Rock, and the Bowie-Miller Counties Medical Society Tumor Clinic, Texarkana, have this distinction. With the good work being done by the Sebastian County Tumor Clinic, Fort Smith, and the Southeast Arkansas Tumor Clinic, Pine Bluff, it is anticipated that these can be placed on the ACS approved list in the near future.

Two clinics, those at Texarkana and El Dorado, are developing the cytologic test, employing the Papanicolaou technique in their diagnostic routine.

Cancer Society Cooperation

Attention is due here to the fine cooperation of the Arkansas Division, American Cancer Society, in providing domiciliary care and transportation for indigent cancer patients, who are referred to the seven designated clinics. Referral is made through the Commission office to the clinic nearest the patient's home, and for this purpose a clinical area to be served by each clinic has been mapped out.

A full-time representative of the Cancer Society at University Hospital Tumor Clinic to handle requests for domiciliary care and transportation greatly facilitates this centralized patient load.

American Cancer Society units in counties where these permanent clinics are located can and are making a definite contribution—financial and otherwise—toward supporting the tumor clinic program. Recently the American Cancer Society in Arkansas has approved financial aid to the designated clinics for specified incidental expenses that occur in the successful operation of a

clinic. Some of the hospitals, where the clinics have been equipped and staffed with Commission funds, are absorbing the cost of various items.

The Commission participated in the Training School of the Arkansas Division, American Cancer Society, last November and December, by furnishing speakers. The Commission makes available a projector and cancer film for the Pulaski County Field Army in its educational program.

Hospitalization

Our second objective or responsibility has been to furnish hospitalization for the medically indigent cancer victims of our state. A per diem of \$6.00 has been paid to approved hospitals for this service with 656 patients receiving this service at an expenditure of \$36,314.99, an average cost of \$55.35 per patient, during the last fiscal year, July 1, 1947-June 30, 1948. The Commission approved a schedule of payment for deep X-ray therapy and diagnostic X-ray to radiologists, who treated Commission patients. Payment for this new service was allowed on the basis of reimbursement for an expendable item and not a doctor's fee.

The Commission served 543 patients from July 1, 1948, through January 31, 1949, the first half of our present fiscal year. And it is anticipated that by June 30, 1949, the end of this fiscal year, our patient load will amount to 1,100 patients.

State Appropriation Doubled

Recognizing the need for the Cancer Commission program and its services, the 1949 General Assembly of Arkansas, recently concluded, appropriated \$50,000 a year for the next two years. This amount is double the Commission's original appropriation of \$25,000, which has been the total of state funds for operation each year. This concrete evidence of approval is a tribute to members of the medical profession, who give their skill and time to the cancer control program without remuneration.

Arkansas' grant-in-aid funds from the United States Public Health Service for the new fiscal year, beginning July 1, 1949, are estimated to be \$42,995. This allotment is made on a formula basis, coming from the \$2,500,000 of federal funds for cancer control. Only diagnostic hospitalization during the first three days may be provided by federal monies.

Statistical Studies and Tumor Records

Statistical studies of the cancer problem in Arkansas, a third objective of the Commission program, is well on the way, with detailed standard Tumor Records executed for each patient attending the Tumor Clinics. Follow-up procedure in our designated clinics records the patient's condition every three months, six months, year or two years, determined by the Clinic Director.

Educational Program

A portion of the federal funds administered by the Commission go toward cancer education for members of the medical profession. During this fiscal year one of our Tumor Clinic co-directors took a refresher course at Memorial Hospital, New York City, and a Tumor Clinic secretary attended a Cancer Nursing Institute in St. Louis, where only registered nurses were accepted.

Funds of the Commission bring out-of-state specialists in the cancer field to speak before the Arkansas Medical Society, cooperating with the Society's Cancer Control Committee. It is our plan to make available to all district medical societies in the near future a new scientific and professional film, the first of a series on "Cancer: The Problem of Early Diagnosis."

The Commission is cooperating with the Arkansas State

Health Department in its Cancer Institute for public health nurses to be held May 9-13 at the Cancer Investigation Center, Hot Springs, where the United States Public Health Service is concerned with the testing and development of cancer diagnostic tests. As you know, all cancer and cancer suspect cases detected at this Center become the responsibility of the Commission, which in turn refers these patients to the Tumor Clinic nearest their homes for further diagnosis and treatment.

For public information and interpretation of the Commission's program and services, over 5,000 printed leaflets giving facts and figures were distributed to individuals and organizations.

The acting director and administrative assistant represented the Commission at the National Cancer Conference, held at Memphis in February, and at the American Public Health Association, held at Boston in November. On both occasions it was inspiring to see clinicians in all fields of the medical profession, public health officials, and representatives from the great army of volunteer workers meet to discuss the control of cancer.

Association of Tumor Clinic Staff Members in Arkansas

At a statewide scientific meeting for Tumor Clinic staff members in Arkansas, held March 20 in Little Rock, with over 50 doctors participating, an Association of Tumor Clinic Staff Members in Arkansas was organized with Dr. W. G. Cooper, Jr., chairman. This group will meet at specified intervals to provide for closer association of members of the medical profession, who are interested in cancer; to discuss mutual problems of designated permanent tumor clinics; to promote regular scientific sessions on cancer; and to stimulate members to prepare material for presentation and for publication in cancer journals.

The Commission was host to Tumor Clinic directors and Tumor Clinic secretaries at an all-day session last October, when clinic procedure and organization were discussed.

Memorial Gift of Radium

Three thousand dollars for the purchase of 100 milligrams of radium and accessory equipment were given to the Commission last December by Miss Hope Hardy, as a memorial to her late father, M. W. Hardy. This radium is for the use of indigent cancer patients at designated tumor clinics.

Classification and Compensation Plan

Personnel in the Commission's central office, State Health Building, and in the designated tumor clinics over the state, now numbers thirteen. Specifications for these positions as well as for those anticipated in the future have been incorporated in the Commission's Classification and Compensation Plan, as required for all agencies participating in federal funds. Final formal approval of the plan was accomplished in January.

Evaluation of Program

Now on the threshold of the Cancer Commission's fifth year, we shall be able to evaluate our program and get a good perspective of just what has been accomplished by our expenditure and our efforts.

At the conclusion of this incoming fifth year, acceptable figures on five-year cures will be available.

Cancer and cancer suspect cases have been educated to report to cancer clinics for diagnosis and treatment, thereby making possible early diagnosis. Due to early diagnosis, there has been a downward trend in cancer mortality and there has been an upward trend in cancer morbidity. This picture is conclusive from national statistics. The family physician, the doctor, the specialist, here in Arkansas, each has served as an axis or a pivot-

basis in the cancer control program. He has seen more cancer and learned more about cancer.

Cancer is more curable today than it has ever been. Early diagnosis and treatment, linked with intense laboratory investigation, may well result in significant advances within our time.

REPORT OF DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

D. A. RHINEHART, Delegate

(Read by R. B. Robins, Alternate)

As Alternate to Doctor D. A. Rhinehart, the regularly elected Delegate of the Arkansas Medical Society to the American Medical Association, I served during the Interim Session of the American Medical Association at the past December session and desire to make the following report:

As you already know, the feature action of the House of Delegates at this meeting was the appointment of a ten-man National Policy Committee to be known as the Coordinating Committee, or the National Committee for the Protection of the People's Health. As your delegate I received an appointment on this committee and have been very busy since that time with the duties of the committee.

The purpose of this committee is to conduct a national educational campaign directed to the American people to preserve the American way of the practice of medicine by promoting voluntary health insurance and opposing compulsory federal health insurance or so-called socialized medicine.

In order to implement this campaign, action was taken by the House of Delegates to assess each doctor in the United States a special assessment of \$25. This money is to be used in this educational campaign and none of it is to be used for lobbying purposes in Washington as some people have stated. We desire to get the record straight on that particular point.

A number of other actions of the House of Delegates at this meeting are significant to all of us. We endorsed such projects as a national enrollment agency for Blue Shield, a drive to make rebating unlawful in all states, and a proposal for full-time public health units at local and county levels. We blackballed recommendations for a Blue Cross-Blue Shield National Health Service, for a special drafting of doctors, and for Federal subsidies for medical schools.

The House of Delegates did not approve a national insurance company because it was thought that benefits and premiums could be better arranged on a local basis. It was thought better to continue to try these plans on a state level rather than to venture out with one company on a national level and take the chance of a possible collapse of the entire effort. It was felt that not enough experience had yet been accumulated to make such a broad venture.

As I have said, the House of Delegates disapproved the drafting of doctors hoping that this would not be necessary. It was hoped that the young doctors would volunteer for military service. Those who were deferred from a shooting war to complete their education owe an obligation to their country at this time to serve. It is, at the present moment, up to these young men as to whether a doctor draft will be necessary.

The House of Delegates opposed Federal subsidies to education, at this time, hoping that voluntary fund-raising would be thoroughly explored first.

The body also asked for a revamping of medical school courses with an eye to redesigning general practice.

It was a very eventful session of the American Medical

Association and I enjoyed the privilege of serving as one of your delegates.

REPORT OF THE COUNCIL

JOHN H. WILSON, Chairman

The Council met on October 10, 1949. The action taken and the recommendations made are herewith submitted to the House of Delegates, and are as follows:

(1) Authorized a \$10,000 non-interest bearing loan to the Joint Committee of the Arkansas Medical Society and the Arkansas Hospital Association for the activation of the Blue Cross-Blue Shield Plan in Arkansas.

(2) Authorized an annual contribution of \$250 to the Woman's Auxiliary to the Arkansas Medical Society.

(3) Recommended the honoring of the "Arkansas General Practitioner of 1949" at the 1949 Annual Session, this physician to be voted upon by the House of Delegates from a group of three candidates from nominations by the county medical societies to be selected by the Committee on the 50-Year Club.

At the meeting of the Council on November 21, 1948, the following action was taken:

(1) Approved the plan and site of construction of the Medical Center as presented by the Committee on Medical Education and Hospitals.

(2) Appointed a committee of five councilors to investigate the field for an attorney to fill the vacancy left by the death of Carl Bailey.

(3) Authorized the Committee on Medical Education and Hospitals to investigate the so-called "hospital practice of medicine" existent in the state.

The Council met on December 19, 1948, and took the following action:

(1) Approved the special American Medical Association \$25 assessment on all members of the Society.

(2) Appointed a special planning committee of eight to direct the campaign in Arkansas against compulsory health insurance legislation.

(3) Resolved to disapprove any "hospital practice of medicine" in the state.

At the meeting of the Council on January 23, 1949, the following action was taken:

(1) Appointed D. A. Rhinehart to the Committee of 53 Physicians of the American Medical Association.

(2) Resolved to recommend to the chairman of the University of Arkansas Board of Trustees that students (medical) receive state financial assistance upon their bonding to practice in towns of 1,000 population or less.

At the meeting of the Council on February 13, 1949, the following action was taken:

(1) Expressed opposition to amendments to H. B. 225, if amendments were accepted.

(2) Voted opposition to S. B. 230.

(3) Endorsed H. B. 313.

The Council met on February 27, 1949, and took the following action:

(1) Authorized the disbanding of the special Planning Committee and the formation of a new committee, to be composed of the Councilors as ex-officio members with one additional member from each Councilor district, to carry on an educational campaign in the state regarding passage of compulsory health insurance and to cooperate fully with the American Medical Association.

(2) Appointed the Auxiliary President and President-Elect to the Committee for the Extension of Medical Care.

By a special mail vote on March 15, 1949, the Council took the following action:

(1) Authorized the employment of a stenographer by the executive secretary.

(2) Authorized the purchase of needed office equipment for the executive secretary's office, including typewriter, desk, chair, mimeographing machine, addressing machine and file cabinet.

At the meeting of the Council on April 3, 1949, the following action was taken:

(1) Accepted the resignation of M. C. Hawkins, Jr., Councilor, Second District, recommending the appointment to fill the unexpired term be deferred until the meeting of the House of Delegates.

(2) Appointed George Steinkamp to represent the Society at the National Health Council Regional Conference, Kansas City, April 20-22, and authorized expenses for a representative of the Woman's Auxiliary.

(3) Recommended the formation of a Committee on Hospital Relations as a subcommittee of the Committee on Medical Education and Hospitals.

(4) Nominated for Life Membership D. M. G. Frailey, J. O. Rush, H. L. Montgomery and W. F. Rogers.

(5) Approved the petition requesting the combining of Cross and St. Francis County Medical Societies into the Cross-St. Francis County Medical Society.

(6) Authorized a \$250 fund for the use of the Woman's Auxiliary in the present education campaign against federal compulsory health insurance

(7) Approved recommendation to the House of Delegates that Annual State Membership dues be raised to \$20.

(8) Authorized the sum of \$10 for every deceased Society member during the past year be contributed to the Ilse Oates Student Loan Fund of the Woman's Auxiliary.

(9) Approved for presentation to the House of Delegates resolutions condemning the passage of compulsory health insurance and approving the Arkansas Blue Cross-Blue Shield Program.

At the meeting of the Council on Wednesday night, April 13, 1949, the following action was taken:

(1) Names of the three candidates for the Outstanding Arkansas General Practitioner of 1949 would be referred to the House of Delegates for election.

(2) Authorized expenses of the 73rd Annual Session paid.

(3) Approved resolution condemning all forms of compulsory health insurance.

On April 14th, the Council made the following recommendation:

(1) Recommended that selection of the nominees to fill the vacancies on the State Board of Medical Examiners and on the State Board of Health be made by the delegates from the respective congressional districts.

REPORT OF THE TREASURER

PAUL L. MAHONEY, Treasurer

Balance, April 1, 1948:

Treasury bonds	\$11,400.00
Bank account	2,501.75
	<hr/>
	\$13,901.75

Receipts:

From Secretary	\$45,000.00
Interest—Treasury Bonds	285.00
Employees' taxes withheld	827.35
	<hr/>
	\$46,112.35

	13,901.75
	\$60,014.10
Disbursements	\$39,242.06
Balance, March 31, 1949:	
Treasury bonds	\$11,400.00
Bank account	9,372.04
	\$20,772.04
In hands of Secretary for transfer to Treasurer..	\$ 7,652.53
Total balance, March 31, 1949	\$28,424.57

REPORT OF THE EXECUTIVE SECRETARY

MR. SID WRIGHTSMAN, JR.

The Society employed your executive secretary on May 10, 1948. The following month, suitable office space was found at 310 Professional Building, Fort Smith, where at the present time, under the guidance of your secretary, headquarters activities are maintained.

During the year, your executive secretary was sent to the offices of the Oklahoma State Medical Association to observe and study routine activities undertaken at a typical state medical association headquarters, the duties involving the state association executive secretary. He attended both the Annual and Interim Sessions of the American Medical Association to familiarize himself with actual procedures of the House of Delegates thereat and to meet executive secretaries of other state medical associations and their officers. Frequent opportunities were awarded throughout the year to visit meetings of both county and councilor district medical societies where intimate contacts among Society members were established. In January, he spent three days at the State Legislature observing procedures and meeting district representatives and senators. In his opinion, progress in and increased understanding of his position in the Society have been achieved as a result of these activities.

Following the national election in November, with the accompanying wave of interest in Truman's compulsory health insurance program, lay organizations, learning of the availability of the Society's executive secretary, have provided him opportunities to explain the evils of political medicine and the benefits inherent in voluntary prepayment plans for medical care.

Following the action of the House of Delegates at the Interim Session of the American Medical Association to assess each member \$25, many members of the Society responded with contributions immediately. To date, 492 Society members have submitted their special assessments, a number representing approximately 40 per cent of the total 1948 membership and a contribution of \$12,300 to the fund, ultimately expected to reach a \$3,500,000 mark, to provide a two-year national education program informing the public about the progress of American medicine, evils of socialized medicine, and the need of increasing over the nation voluntary prepayment medical care plan coverage.

On December 31, there were 1,223 Society members. Today, less than two months since this office received the first payment of 1949 dues, the membership is 591.

For their continuous cooperation and many courtesies shown him throughout this past year, the executive secretary expresses much appreciation to members of the Arkansas Medical Society.

By motion (Hunt-Dixon) "Fifty-Year Club" members in the future will receive awards at local county society ceremonies in place of an

award program during the annual sessions.

E. Driver Rowland, chairman of the Committee on Heart, suggested that the in-coming committee be allotted time for discussion of heart disease during future sessions.

Earle H. Hunt presented the names of the three candidates for selection as "Arkansas General Practitioner of 1949": M. L. Norwood, Lockesburg; T. E. Rhine, Thornton; and E. E. Ellis, Fayetteville. Following discussion of candidates' qualifications by R. B. Robins, R. C. Dickinson and Fount Richardson, ballots were cast and T. E. Rhine was elected.

By motion (Richardson-Brown) nominees to the State Medical Board of the Arkansas Medical Society are to be selected by delegates from counties comprising each Congressional District.

The following members were nominated to fill vacancies occurring in the following congressional districts: SECOND—W. J. Ketz, Sam J. Allbright and M. L. Harris; THIRD—W. H. Poyner, Friedman Sisco and Ross Fowler; SIXTH—C. H. Lutterloh, H. T. Smith and S. A. Drennen; SEVENTH—John H. Wilson, R. B. Robins and G. D. Murphy, Jr.

The House then proceeded to select the following Nominating Committee: First District, L. H. McDaniel; Second District, O. J. T. Johnston; Third District, J. O. Rush; Fourth District, H. T. Smith; Fifth District, G. D. Murphy, Jr.; Sixth District, H. E. Murry; Seventh District, C. H. Lutterloh; Eighth District, T. Duel Brown; Ninth District, D. L. Owens and Tenth District, J. M. Kolb.

The House then adjourned.

Thursday Night, April 14th, 1948

A public meeting was held in Robinson Memorial Auditorium at 8 p. m. with the following program: "The Scheme for a National Compulsory Health Insurance Program," Marjorie Shearon, Ph. D., Washington, D. C., and "What Socialized Medicine Has Meant to Britain," Mr. Cecil Palmer, London, England. R. B. Robins, Camden, presided as moderator.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Friday Morning, April 15th, Hotel Marion

The meeting was called to order by Chairman Ogden.

The scientific program proceeded in order.

Chairman's Address—Fred Ogden, Fayetteville.

"Ocular Muscles," Richard G. Scobee, St. Louis.

"Treatment of External Otitis," Ben Senturia, St. Louis.

A round-table luncheon followed.

Officers elected are:

Chairman—C. G. Hinkle, Batesville.

Vice-Chairman—Fred Ogden, Fayetteville.

Secretary—K. W. Cosgrove.

THIRD GENERAL SESSION

April 15, 1949—9:30 A. M.

The meeting was called to order by Vice-President Rush, in absence of President Lutterloh, and the scientific program proceeded in order.

"Differential Diagnosis and Treatment of Inguinal Hernia," A. D. Garner, Paragould.

"Newer Management of Carcinoma of the Bladder by Cystectomy," H. Fay H. Jones, Henry Hollenberg, W. G. Cooper and James W. Headstream, Little Rock.

"Diagnosis and Treatment of Poliomyelitis," Edward S. Miller, Denver.

"Treatment of Diseases of the Thyroid," George Crile, Jr., Cleveland.

MEMORIAL SESSION

April 15, 1949

The meeting was called to order by President Lutterloh at 11:40 A. M.

The invocation was given by Rev. Wilbert Koenig, First Lutheran Church, Little Rock.

A musical selection, "Another Temple Waits the Lord," was given by Miss Billie Jean Templeton, accompanied by Mrs. John H. Summers.

Mrs. E. L. Thompson read the name of a deceased member of the Auxiliary.

President-Elect Smith read the names of the following deceased members:

IN MEMORIAM

John Trimble Palmer, Pine Bluff, May 25, 1948.
David Troy Cheairs, Little Rock, May 28, 1948.
William A. Pickens, Bentonville, June 10, 1948.
James J. Hudgins, Paragould, June 12, 1948.
Wilfred R. Parsons, Little Rock, June 13, 1948.
Oscar Gray, Sr., Little Rock, July 1, 1948.
Edward Martin Miers, Mena, July 9, 1948.
John Henry Moore, Delaware, July 16, 1948.
Crandall P. Sisco, Springdale, August 24, 1948.
John Riley Loftis, Pocahontas, September 15, 1948.
William D. Burch, Hughes, October 2, 1948.
E. G. Fendley, Leslie, November 1, 1948.
Alexander M. Lisenbee, Sparkman, November 11, 1948.
C. J. Martin, Hindsville, November 19, 1948.
William R. Orr, Helena, December 1, 1948.
Walter H. Simmons, Pine Bluff, December 15, 1948.
R. M. Barrett, Black Oak, December 27, 1948.
T. W. McDaniel, Boughton, January 3, 1949.
Herman W. Hundling, Little Rock, January 8, 1949.
Charles E. Spivey, Hamburg, January 13, 1949.
James H. Hamner, Aubrey, January 31, 1949.
Grover Cleveland Debolt, Little Rock, February 2, 1949.
W. W. Hatcher, Imboden, February 9, 1949.
J. O. Leslie, Marshall, February 9, 1949.

Augustus C. Shipp, Little Rock, March 22, 1949.

Samuel P. Stubbs, Fort Smith, March 23, 1949.

Past-President W. H. Mock read the Twenty-Third Psalm.

L. H. McDaniel, Tyronza, gave the Memorial Address.

Another year has passed since our Memorial Services twelve months ago when we paid our humble and heartfelt respects to those physicians of our group who had responded to that eternal summons that knows no refusals and accepts no delays—another year with its sunshine and its shadows, its laughter and its tears, its sowing and its reaping, its cradle songs and funeral hymns has passed, bringing each one of us here today nearer the fateful hour when we, too, will join that lamented group of honored physicians and brothers in the profession whose names our good President-Elect has just read to you. Surely the few moments we ponder on the lives, the accomplishments, and the achievements of that group whose earthly endeavors have been laid down—leaving us the memories of those lives of service to their fellowman or recollections of their tenderness to those in pain or distress—surely, I say, those moments spent in the reverence and honor of our departed brothers are moments that should be cherished forever.

That textbook of the Christian religion which we call the New Testament refers to one of its writers as "The Beloved Physician." Most physicians could still be designated by that title even during their active lives. And though the community takes them and their services as matters of course, when death removes them from this earthly scene they are then viewed in a clearer light, and to them then is applied the greatest of all titles, "Beloved."

It was said of Him whom millions called Saviour that He saved others, Himself He could not save. These same words, in a very real sense, may be spoken of the beloved physicians whom we memorialize today. The list as read by our President-Elect shows that Death has not been idle this past year. We rejoice that the Auxiliary has very few members to include in our eulogy today. In a way that goes to show that the good wives are spared some of the worries and hardships that take their toll of our physicians. In the performance of their duties they were unable to save themselves from long hours, physical weariness, mental anxiety and other exactions which many men escape. But because they did not seek to save themselves, others were saved.

These departed physicians whom we memorialize today exhibited as little of the defects of their environment and as much of its virtues as any group of men we could find. They had the kind of generosity which seems to thrive among men who practice an art and not among men who drive bargains. They had discretion tested by the keeping of a thousand secrets. They had a tact which developed out of many embarrassments. Their cheerfulness brought courage to the sick room even when they could not bring healing.

They knew the rich as well as the poor, and they did not truckle to the one, nor spurn the other. They knew the people called good and the people who were called bad, and their penetrating eyes saw more than mere anatomy. They saw how vice and virtue intertwine, how the bold are often weak, and the meek are often strong and courageous. For all alike, they had compassion. They saw and realized that their mission was not to condemn but to serve.

They were "beloved" physicians because men and

women clung to them as they drew back from the Valley of the Shadow.

And they held the trembling hands,
And kept fear at bay and faith alive,
They watched while others slept,
They held their tears while others wept;
With nerves as true as tempered steel
They felt, yet dared not seem to feel;
With steady hands that dared not quake
They played the game, with life the stake.
While others engaged in petty strife
Theirs was the war of Death and Life.
They gave to the new-born babe its breath,
They folded the hands growing cold in death.
Ah! Death, that ruthless foe which they had to meet,
A foe that knows no full defeat,
But makes a seeming retreat today
And returns tomorrow to the fray.

As we look back today upon our comrades in the practice of medicine, and search our minds for words and figures of speech to voice our appreciation of them, we discover that we are quite indifferent to externals. It matters not so much with us whether their faces still were fair, or "lined and grayed to mark the slipping years!" Our interest lays hold on their honesty and dignity with which they graced our profession. They made the crooked straight and healed old sores; They made the blind to see, the wounded clean and whole. Fears fled, hope came wherever they touched the doors. To serve their suffering fellowmen was aim and end and goal.

We honor ourselves today, even more than we honor our departed fellow-physicians, when we make a place in our program for this tribute to their memory. In a very real way we have entered into their labors and our service to mankind is strengthened because they lived.

From the Castle Rock which dominates the city of Edinburgh, four buglers blow "the last post" at the sunset of every day. As you know, "the last post" in the British Army is equivalent to our taps. There is a tradition that in ancient times it was customary for five buglers to blow "the last post." But on a March-end long ago one of the buglers was murdered, and since that day the buglers have been limited to four. And there is a sort of half-belief among Edinburghers that on every March 31st, when the last notes of the four buglers have died away, listeners in quiet places, if their hearts are quiet, and their minds are receptive, can hear the faint, far-off notes of the fifth bugler sounding as of old. This, of course, is a tender fancy, but it illustrates a noble truth, namely, that from the Castle Rock of our profession there are vanished buglers calling. Ah! my friends, as I listen I fancy that I hear each of those "vanished buglers" we honor today in this Memorial Service, sounding the clarion call—distant, yea, but still so distinct—for us to carry on the fight against human disease and human misery. Ah! my friends, does not that distant note come from Frank Vinsonhaler, G. W. Warren, C. W. Garrison, Turner Wooten, Sid Wolferman, A. G. Henderson, Ira Ellis, J. L. Baird, Edward C. McDaniel, Thad Cothorn, R. H. T. Mann, Sam Thompson, Val Parmley, C. M. Lutterloh, W. H. Bathurst, Morgan Smith, J. T. Altman and many others just as deserving who are not mentioned for lack of time—that group of men who answered the call of duty to palace and hovel alike—that group of men who heard secrets and confessions not breathed to other mortals—that group of men who were so often called upon to whisper consolation to some poor suffering soul on the brink of this earthly

silence—that group of men who were trusted with everything morial that this life affords—that group of men who labored through love under a system we know as Medical Ethics, the ideals of which are not surpassed by any organization, religious or otherwise—that system which in its ultimate analysis is but a continuation of the Sermon on the Mount by the Great Physician—that One who ever directs the internist's diagnosis or the surgeon's hand.

Several months ago, I was present during a serious operation in St. Bernard's Hospital in my neighboring town of Jonesboro. Near the climax of the operation the skillful surgeon temporarily lifted his eyes to a large plaque hanging over the entrance into the operating room. After four or five seconds a new light of confidence seemed to radiate from the face of that Christian gentleman—your present State President—and he went on and rapidly completed the successful operation. The poem on that plaque has made a tremendous impression upon my mind and heart—and I have had the Sisters duplicate that plaque many times as gifts to my physician-friends. I am sure they would duplicate it for any of you. May I now quote that poem entitled "The Physician's Prayer":

Lord, Thou on earth didst minister
To those who helpless lay,
In pain and weakness hear me now
As unto Thee I pray.
Give to mine eyes the power to see
The hidden source of ill,
Give to my hand the healing touch
The throb of pain to still.
Grant that mine ears be swift to hear
The cry of those in pain;
Give to my tongue the words that bring
Comfort and strength again.
Fill Thou my heart with tenderness,
My brain with wisdom true,
And when in weariness I sink,
Strengthen Thou me anew.
So in Thy footsteps may I tread,
Strong in Thy strength always,
So may I do Thy blessed work
And praise Thee all my days.

George Eliot, in the "Mill on the Floss," gives the legend of St. Ogg. Ogg was a boatman who gained a scant living by carrying passengers across the River Floss. One evening when the winds and waves were high, there sat moaning on the river's bank a woman with a child in her arms. She was clad in rags, and there was a worn and haggard look on her face. She begged to be rowed across the river. Others bade her wait till morning, and asked her why she desired to cross. Ogg came to her and said, "I will ferry thee across, thy need is most urgent and thy heart above all desires it." Battling with all of his power against the wind and waves, he ferried her across. As she stepped ashore, her rags were changed into a robe of flowing white, her face became exceedingly beautiful, and her brow was hallowed with a light, like the brightness of the moon, until it cast a silvery light upon the water.

She said, "Ogg, thou art blessed in that thou didst not question the heart's need, but was smitten with pity and didst straightway relieve the same; henceforth whosoever steps into thy boat shall be in no peril from the storm, and when it puts forth to rescue, it shall save the lives of men and beast." When the floods came many were saved by the blessing on the boat.

The legend goes on: "When Ogg's spirit was parted

from his body, his boat slipped its mooring at the river's bank and went drifting rapidly to sea with the tide, until it was seen no more. Down the years in times of storm, a phantom boat might be seen in the river. At the oars sat Ogg, and in the prow a woman dressed in a robe of flowing white, and around her a halo of light, like the brightness of the moon, that cast a silvery light upon the water. As the toilers saw this vision of the phantom boat and the Madonna, their arms were made strong and their hearts brave for the work of rescue." I love to compare the every-day general practitioner with his heart of gold, those departed physicians we honor today, if you please, to the good Saint Ogg.

The story is told that a noted actor in London, England, was retiring after a number of years of great popularity on the stage and radio. He was beloved and admired by all in that country who had heard him or seen him in action. On the eve of his retirement a huge banquet was given in his honor at the largest hotel in London and a great throng had gathered to pay him honor. He was attempting to thank those assembled for their presence in honoring him and was continually being interrupted by those in the audience with the request that he again recite the Twenty-third Psalm. It seems that he had been noted for his rendition of this Psalm on stage and radio on numerous occasions. I would compare him with the noted actor in this country, Lionel Barrymore, who has on so many occasions played the part of Scrooge in the beautiful play, "A Christmas Carol," or our own Dr. Willie Mock, if you please.

Finally the actor stopped what he was saying and told the group that he would again recite the Psalm for them if, following his recitation, they would listen to his old minister friend, who was seated at his right at the table, give his rendition of the Twenty-third Psalm. With this understanding, the actor, with all the ability he possessed through his years of experience, started with, "The Lord is my shepherd, I shall not want, He maketh me to lie down in green pastures: He leadeth me beside the still waters: He restoreth my soul: He leadeth me in the paths of righteousness for His name's sake. Yea, though I walk through the Valley of the Shadow of Death, I will fear no evil—" and so on through the Psalm. When he had finished there was thunderous applause that lasted for minutes, and finally the actor raised his hand to quiet the group and said, "Remember now, you were to hear the Psalm recited by my old minister friend. It was he who taught me the Psalm, who baptized me, and although I feel that I have not lived up to all that he has taught me, I give him credit for much of my success in life. Listen now to him."

The old minister was very feeble with the weight of many years, and with a cracked voice that was in direct contrast to the melodious voice of the actor, he stood before the microphone of the public address system and started the Psalm: "The Lord is my shepherd, I shall not want, He maketh me to lie down in green pastures: He leadeth me beside the still waters: He restoreth my soul: He leadeth me in the paths of righteousness for His name's sake. Yea, though I walk through the Valley of the Shadow of Death, I will fear no evil, for Thou art with me: Thy rod and Thy staff they comfort me. Thou preparest a table before me in the presence of mine enemies. Thou anointest my head with oil: my cup runneth over." The mind of the old gentleman wavered. In spite of the fact that he had recited the Psalm thousands of times, the last line slipped him, but he was not perturbed. There was a smile on his face that radiated reverence. He went back and picked up the previous

sentence and then finished with, "Surely, goodness and mercy shall follow me all the days of my life: and I will dwell in the house of the Lord forever." When he had finished, there was no applause. There was instead a reverence of silence. It was as though an angel had whispered in the ear of all present, "Do not applaud. This is too reverent a time to applaud." After a long silence, the actor again went to the microphone and said, "Now, my friends, do you understand why I wanted my minister friend to give you the Twenty-third Psalm? I knew the Psalm—he knew the Shepherd."

My friends, it is my belief and my prayer that each one of those lamented physicians we mourn today—those "departed buglers," if you please—knew the "Shepherd."

A musical selection, "There Is a Green Hill Far Away," was given by Miss Billie Jean Templeton, accompanied by Mrs. John H. Summers.

Rev. Wilbert Koenig pronounced the benediction.

FOURTH GENERAL SESSION

April 15, 1949—2:00 P. M.

The meeting was called to order by President Lutterloh and the scientific program proceeded in order.

"The Practitioner's Problem in Evaluating Thoracic Cases in Light of Modern Antibiotic Therapy," J. K. Donaldson, Little Rock (Lantern Demonstration).

"The Diagnosis and Treatment of Cardiac Arrhythmias," A. Carlton Ernstene, Cleveland (Lantern Demonstration).

"The Present Status of Cancer Therapy," R. Lee Clark, Jr., Houston.

"Diverticulitis of the Sigmoid Colon," Frank G. Kumpuris, Little Rock.

Discussion by S. W. Hawkins, Fort Smith.

"Coronary Artery Disease," Joe Verser, Harrisburg.

Friday Evening, April 15th

The Pulaski County Medical Society was host at a social hour preceding the annual banquet session and dance at the Hotel Marion.

FINAL GENERAL SESSION

April 16, 1949—9:30 A. M.

The meeting was called to order by President Lutterloh and the scientific program proceeded in order.

"Early Diagnosis in Congenital Dislocation of the Hip," S. B. Thompson, Little Rock.

"Hematuria . . . Its Clinical Significance," J. Frank Clark, El Dorado.

"The Treatment of Cardiac Emergencies," A. Carlton Ernstene, Cleveland.

"Diseases of the Pancreas and Biliary Tract," George Crile, Jr., Cleveland.

"Medical Legislation," Carl Hendrix, Speaker, Arkansas House of Representatives.

Earle H. Hunt, Clarksville, made the special medal award to T. E. Rhine, Thornton, chosen by the House of Delegates as the Outstanding General Practitioner of 1949.

Past-President R. B. Robins introduced Dr. Rhine, who acknowledged the presentation.

FINAL SESSION, HOUSE OF DELEGATES

Saturday Afternoon, April 16, 1949

The House of Delegates was called to order by President Lutterloh.

The Secretary called the roll of the delegates.

The following delegates and county society members seated as delegates by action of the House of Delegates (motion Fount Richardson-Frank Kumpuris) were present:

ASHLEY—W. A. Regnier; BENTON—G. A. Hughes; BRADLEY—W. J. Hunt; CHICOT—S. W. Douglas; COLUMBIA—C. L. Weber; CRAIGHEAD-POINSETT—J. H. McCurry, Joe Verser; CROSS-ST. FRANCIS—J. O. Rush; DESHA—H. T. Smith; FRANKLIN—C. C. Long; GARLAND—C. H. Lutterloh; GREENE-CLAY—A. D. Garner; HEMPSTEAD—Jim McKenzie; HOWARD-PIKE—W. H. Toland; INDEPENDENCE—O. J. T. Johnston; JEFFERSON—Fred Hames; JOHNSON—J. M. Kolb; LITTLE RIVER—Elmer Davis; MADISON—Charles Beeby; MILLER—Harry E. Murry; POLK—F. A. Lee; POPE-YELL—Roy I. Millard; PULASKI—T. D. Brown, Charles R. Henry, Daniel H. Autry, Fred W. Harris, Hoyt R. Allen, John Samuel, Frank Kumpuris, George R. Steinkamp, Robert D. Jones, Elvin Shuffield, and Edwin F. Gray; SEBASTIAN—A. F. Hoge, F. H. Krock; SEVIER—C. E. Kitchens; UNION—G. D. Murphy, Jr., H. J. Mayfield; WASHINGTON—Fount Richardson; WHITE—Porter R. Rodgers; EENT SECTION—R. J. Calcote.

Other members of the House of Delegates present were:

President Lutterloh, President-Elect Smith, Councilors McDaniel, Owens, Drennen, Gay, Hundley, Hunt, Dickinson, Martin, and Wilson; Past-Presidents Shuffield, Jones, Robins, Wade and Allbright.

L. H. McDaniel presented the report of the Nominating Committee:

President-Elect—Earle H. Hunt, Clarksville; Hoyt R. Allen, Little Rock.

First Vice-President—Charles R. Henry, Little Rock.

Second Vice-President—Joe B. Wharton, Jr., El Dorado.

Third Vice-President—Harry E. Murry, Texarkana.

Secretary—W. R. Brooksher, Fort Smith.

Treasurer—Paul L. Mahoney, Little Rock.

Councilor, First District—L. H. McDaniel, Tyrone.

Councilor, Second District—J. J. Monfort, Batesville.

Councilor, Third District—S. A. Drennen, Stuttgart.

Councilor, Fifth District—John H. Wilson, Magnolia.

Councilor, Seventh District—L. G. Martin, Hot Springs.

Councilor, Ninth District—D. L. Owens, Harrison.

Councilor, Tenth District—Fount Richardson, Fayetteville.

Delegate, American Medical Association—R. B. Robins, Camden.

Alternate, American Medical Association—D. A. Rhinehart, Little Rock.

By motion (Rush-H. T. Smith) report of the Nominating Committee was accepted.

By motion (Harris-O. J. T. Johnston) all nominees other than president-elect were elected by acclamation. The delegates then cast their votes for president-elect.

By vote of the House of Delegates, Earle H. Hunt was elected president-elect.

By motion (Allen-Kolb) the election of Dr. Hunt was made unanimous.

The report of the Reference Committee was read by Ellery C. Gay, chairman.

REPORT OF THE REFERENCE COMMITTEE

ELLERY C. GAY, Chairman

The following committee reports which bear no specific recommendations are accepted and approved as prepared in the Journal:

1. Committee on Medical Economics.
2. Committee on Cancer Control.
3. Committee on Maternal Child Welfare.
4. Committee on Liaison with the Arkansas Tuberculosis Association.
5. Committee on Industrial Health.
6. Committee on Emergency Medical Care.
7. Committee on Rural Health.
8. Committee on Veterans Administration Medical Care Program.
9. Report of the Arkansas State Cancer Commission.

Committee on Arrangements and Scientific Work

The work of these committees speak for themselves and commendation is given by the entire Society to these two committees for their splendid work and the appreciation of the entire State Society extended these men for their splendid service during the past year in the interest of the medical profession. The Reference Committee recommends that dates of Wednesday, Thursday and Friday be considered for our next year's meeting.

Committee on Medical Legislation

This committee report is accepted and approved. The following recommendation is made: That an individual be employed by the State Society, salary to be deter-

mined later, who will be paid from funds collected by the Medical Examining Board, and the State Medical Society. The duties shall be to assist the Legislative Committee, the Examining Board, and the Basic Science Board, in the control of illegal practice in the State of Arkansas. It is recommended also that the details of this be left for the Legislative Committee, the Examining Board and the Basic Science Board and the Council to work out and complete during the coming year. So that such office may be approved and filled as soon as practical.

Committee on Medical Education and Hospitals

This report reflects an enormous amount of work during the past year, and the Committee is to be commended for its efforts. It is called to the attention of the House of Delegates that the 1948 House of Delegates went on record as disapproving Government subsidy of medical education in any form. That section of the committee report, which reads as follows: "The School of Medicine is closely affiliated with the State Board of Health through the professional work of maternal and infant care, the Department of Pediatrics being completely subsidized from this Society." It is recommended that every effort be made to terminate the complete subsidization of this department and place its activities on the same basis as other departments of the University activities and income. That portion of the report which reads: "It would be well to point out that all patients classed in 'D' category are considered to be patients who are not medical indigents and who can be referred to a physician of their own choosing for medical service. It would appear only fair that those who can make some contribution toward the operation of this service, should make a contribution in keeping with their financial ability, and it is further believed that by so doing patients will not be humiliated by the fact that they are, strictly speaking, 'charity patients.'"

The Reference Committee calls attention to the fact that the Council of the Arkansas Medical Society, by resolution in 1948, has disapproved the hospital practice of medicine. The Reference Committee does not feel it can approve a program of charges, based on the ability of the patient to pay, unless it is specifically stated that only those patients in the lower two brackets of income be accepted by the University Hospital and the Isaac Folsom Clinic for professional service. The Reference Committee recommends the adoption of the following resolution:

That the Arkansas Medical Society goes on record as disapproving the hospital practice of medicine and that those patients not in the lower two categories be referred back to their own community and family physician for necessary medical attention.

It is also recommended that a copy of these two resolutions be forwarded to the authorities of the University of Arkansas Medical School.

Committee on Health and Public Instruction

The report of this committee is accepted and approved. The Reference Committee offers the following resolution for adoption:

That the Arkansas Medical Society, realizing the need for more efficient and adequate health workers within the state, goes on record as approving a general upward revision of salaries of state and local public health agencies in keeping with the same service and salaries in adjoining states, and that a copy of this resolution be forwarded to our state officials.

Committee on Scientific Exhibits

The report of the committee is accepted and the com-

mittee commended for its fine presentation of scientific exhibits. The recommendations of the committee for space and general call to attention of the entire body has already been met at this session. The generous offer of the Southern Clinic at Texarkana to the Scientific Exhibit Committee receives our recommendation of approval by the entire State Society.

We recommend that the type of awards, selection of judges, and presentation of awards, be left to the Scientific Exhibit Committee, and that a proper time shall be allowed during the next annual meeting for presentation of such award.

Committee on Necrology

This committee is commended for its excellent memorial service.

Committee on the Heart

Report of this committee is accepted and approved and the committee commended for its excellent organizational activities. The membership of the Society is urged to participate in this program wherever possible.

Committee on Post-Graduate Study

This report is accepted and approved and the committee commended for service during the entire year.

It is proposed that the Committee on Post-Graduate Study shall become a subcommittee of the Committee on Medical Education and Hospitals. The recommendation of the Post-Graduate Study Committee for a plan of rotation of appointed doctors to this committee is accepted and approved and the recommendation is given to the House of Delegates that authority be given to the Committee on Medical Education and Hospitals to follow this proposal.

Committee on the Auxiliary

The report of this committee is accepted and approved and the Committee on the Auxiliary and the Auxiliary as a body is commended for splendid service throughout the year. The following recommendations are approved by the Reference Committee:

1. That the President of the Woman's Auxiliary be offered an invitation to each Council meeting where the business of the meeting warrants such invitation. She is to be present without vote for the purpose of keeping her informed on the policies and activities of the Medical Society.

2. An annual allowance of \$500 for the President and \$100 for the President-Elect of the Auxiliary for reimbursement for travel expenses.

3. Payment of dues for membership in the Arkansas Legislative Council.

4. Appropriation of the usual fund for publishing minutes of the State Meeting.

5. Designation of one member of each County Society as Advisor to that Society's Auxiliary.

Committee on Mental Hygiene

The report of this committee is accepted and approved and the recommendations of the committee approved as follows:

1. The Arkansas Medical Society endorses and supports the State Mental Hygiene Society.

2. Establishment of a separate institution near one of the teachers' training colleges in the state for the retarded children requiring institutional care.

3. Establishment of a separate institution for the non-psychiatric epileptics.

4. Approves the establishment of the Medical Center on the State Hospital grounds.

5. That a competent and qualified psychiatric service be provided the penal and correctional institutions of the

state. This service to be furnished by the Bureau of Mental Hygiene and the State Health Department.

6. Recommendation of this group, which reads: "The Society aid in making available beds in general and regional hospitals for the examination and treatment of the mentally ill" has been considered and the Reference Committee wishes to recommend that before any action is taken an expression should be secured from the Arkansas Hospital Association regarding its desire to participate in the housing of this type of patient.

Joint Committee—Arkansas Medical Society and Arkansas Hospital Association

The report of this committee is accepted and approved. The resolution presented by this committee is as follows:

In the absence of a Liaison Committee with the Arkansas Medical and Hospital Service, Inc., the Joint Committee refers to the House of Delegates the names of Dr. R. C. Dickinson of Horatio, Arkansas, to succeed himself for a term of six years, expiring in 1955; and the second name of Dr. H. T. Smith of McGehee, Arkansas, to serve the unexpired term of Dr. Roy Millard, ending in 1954.

Resolution offered as follows:

WHEREAS, the Committee has fulfilled the mandate given it by the Society, and,

WHEREAS, the Blue Cross, Blue Shield, Voluntary, Non-Profit, Medical and Hospital Plan is now in successful operation, and,

WHEREAS, this plan has been given approval by the AMA and the American Hospital Association,

BE IT RESOLVED, that the Arkansas Medical Society hereby approves the Arkansas Medical and Hospital Service, Inc., and

BE IT FURTHER RESOLVED, that all county societies of the Arkansas Medical Society adopt a Resolution approving the Arkansas Medical and Hospital Service, Inc., as the officially sponsored plan.

Committee on Extension of Medical Care

The report of this committee is accepted and approved. The recommendation of employing a full-time Public Relations Director is passed on to the Council of the Arkansas Medical Society for consideration with the suggestion that it might be feasible to incorporate these duties with the duties of other employed personnel of the Society.

Committee on Committee Reorganization

The report of this committee is accepted and approved. Four additions are made, which are self-explanatory.

Under Paragraph C, No. 7, it is recommended that the following be inserted:

The Liaison Committee, with the Arkansas Medical and Hospital Service, Inc. (Blue Cross-Blue Shield), under Section D, No. 1, change from Planning Committee to Committee for the Extension of Medical Care; under Section D, No. 2, Liaison Committee with the Auxiliary; under Section D, No. 3, Press Committee; under Section E, No. 8, Committee on Hospital Relations.

Report of the State Medical Board of the Arkansas Medical Society

In the absence of a financial report from this committee, the Reference Committee cannot accept this annual report. Recommendation is made by the Reference Committee that the State Medical Board cooperate to the fullest extent with the Basic Science Board and the Legis-

lative Committee and the Council of the Arkansas Medical Society for the purpose of hiring an Executive Secretary, the duties, pay and residency of whom are to be determined by those four groups at subsequent meetings.

Report of Delegates to the American Medical Association

This report is accepted and approved. The following resolution as prepared by these delegates is approved as follows:

WHEREAS, there has been for several years a constantly growing threat to the voluntary method of rendering medical care to the people of the United States, and

WHEREAS, the people of the United States and the Medical Profession rightfully look to the American Medical Association for leadership in matters pertaining to medical care and the welfare of both the people and the profession, and

WHEREAS, the American Medical Association has by action of its House of Delegates at the interim session launched a campaign to educate the public concerning medical care, and,

WHEREAS, this program involves the support of individual physicians, both in spirit and financially, as to the assessment of \$25 placed on each member,

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Arkansas Medical Society heartily endorse the program of the American Medical Association and offer its support both in spirit and in urging members to comply with the assessment, and

BE IT FURTHER RESOLVED, that a copy of this Resolution be sent to the Board of Trustees of the American Medical Association, the Speaker of the House of Delegates, members of its House of Delegates, the Chairman of its Coordinating Committee, and to all members of the United States Congress.

Report of the Council

The following actions have been taken by the Council during the past year and ratification is requested by the House of Delegates:

1. Authorize \$10,000 non-interest bearing loan to the Joint Committee of the Arkansas Medical Society and Arkansas Hospital Association for the activation of the Blue Cross-Blue Shield Plan of Arkansas.

2. Authorize annual contribution of \$250 to the Woman's Auxiliary of the Arkansas Medical Society.

3. Approve the plan and site of construction of the Medical Center as presented by the Committee on Medical Education and Hospitals.

4. Accept action of a committee to investigate the field for an attorney to fill the vacancy left by the death of Carl Bailey, and have obtained the service of Eugene Warren of Little Rock, and Peter Deisch as Counsel for the Arkansas Medical Society.

5. Approve the Special Medical Association \$25 assessment on all members of the Society.

6. Pass a resolution disapproving hospital practice of medicine in the State of Arkansas.

Note: The Reference Committee recommends that the Committee on Medical Education and Hospitals complete their investigation of the so-called hospital practice of medicine in the State of Arkansas and report to the Council as soon as possible.

7. Appoint Dr. D. A. Rhinehart to the Committee of 53 Physicians of the AMA.

8. Resolve to recommend to the chairman of the University of Arkansas Board of Trustees that medical students receive state financial assistance upon their bonding to practice in towns of 1,000 or less.

9. Authorize the disbanding of a special planning committee and the formation of a new committee to be

TREATMENT OF CONSTIPATION IN **mucous colitis**

“The treatment of the constipation in mucous colic does not differ from the treatment of uncomplicated constipation. It is, as always, of great importance to avoid irritating aperients, . . . The stools should be rendered soft and more bulky and therefore more easy to expel with . . . and unirritating vegetable mucilages.”

—Hurst, A., in Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 692.



MUCOUS COLITIS. In this x-ray is shown the distinctive string-like appearance of the descending portion of the lower bowel in mucous colitis, a condition frequently accompanying severe degrees of spastic or atonic colon. In the sagittal section is shown the over-secretion of mucus adhering to the bowel wall.



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composed of the Councilors as ex-officio members with one additional member from each Councilor District to carry on additional campaign in the state, regarding passage of compulsory health insurance and to cooperate fully with the AMA.

10. Authorize employment of a stenographer by the Executive Secretary.

11. Authorize purchase of office equipment for the Executive Secretary's office, including typewriter, desk, chair, mimeograph machine, addressing machine and file cabinets.

12. Appoint Dr. George Steinkamp to represent the Society at the National Health Council Regional Conference in Kansas City April 20th to 22nd, and authorize expenses for a representative of the Woman's Auxiliary.

13. Nominate for life membership Drs. Frailey, Rush, Montgomery and Rogers.

14. Approve petition requesting combining Cross and St. Francis County Medical Societies.

15. Approve recommendation to the House of Delegates that annual state membership dues be raised to \$20.

16. Authorize sum of \$10 for every deceased Society member to be contributed to the Ilse Oates Student Loan Fund of the Woman's Auxiliary.

17. Approve for presentation to the House of Delegates the following resolution:

WHEREAS, the American family has received the finest quality of medical care available in any country in the world developed under our Free Enterprise System, and

WHEREAS, compulsory health insurance wherever tried has caused a decline in national health and deterioration of medical standards and facilities to the detriment of family welfare, and

WHEREAS, compulsory health insurance wherever tried has taken the family's right to choosing its own family physician, and

WHEREAS, invasion of family privacy and violation of the sanctity of the patient-physician relationship have proved to be one of the most objectionable features of compulsory health insurance wherever tried, and

WHEREAS, compulsory health insurance would result immediately in a tax of three (3%) per cent on the income of the American working man, rising within a few years to six (6%) per cent and higher, creating a new tax burden, which would reduce household budgets and bring down family standards of living, and

WHEREAS, Government control of medical services by gradually undermining free enterprise and establishing heavy new tax burdens and unprecedented national deficits would threaten national bankruptcy and encourage the spread of socialism, which would endanger the rights of our children to the individual freedoms which have been the American heritage,

NOW, THEREFORE, BE IT RESOLVED, that the Arkansas Medical Society does hereby go on record against any form of compulsory health insurance, or any system of political medicine designed for National Bureaucratic Control,

That a copy of this resolution be forwarded to the President of the United States, to each Senator and Representative of the State of Arkansas, and that said Senators and Representatives be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

18. Recommend the selection of nominees to fill vacancies on the State Board of Medical Examiners and also on the State Board of Health shall be done by the

delegates from the respective Congressional Districts.

19. Adopt a motion that the AMA be encouraged and requested to become the formal hospital inspecting agency.

Report of the Treasurer

The books were found to be in order and the Treasurer is commended for his work of the year.

Report of the Secretary

The report of the Secretary is accepted and approved and commendation given.

Report of the Executive Secretary

This report is accepted and approved. The Reference Committee makes the following recommendation to the House of Delegates: That within the coming year the office of the Executive Secretary be moved to Little Rock and additional duties and personnel as prescribed by the House of Delegates and the Council of the Arkansas Medical Society to allow for permanent housing of any and all records shall be accomplished.

Recommendations from the Reference Committee

1. In view of the absence of some needed statement of policy and certain amount of inadequacies of our present Constitution and By-Laws, the Reference Committee suggests that a special committee be appointed to redraft the Constitution and By-Laws of the Arkansas Medical Society.

2. That the Secretary of the Society shall publish in the Journal an outline for the presentation of any resolutions desired by the membership so that those resolutions may come through proper channels.

3. The Reference Committee, realizing that precedence has established a meeting night of the Council and Past Presidents, hereby recommends: that a regular meeting of the Council shall be called on the evening preceding the opening of the annual session, and that proper notice shall be carried in the program for the ensuing year.

4. The Reference Committee, at the suggestion of Dr. Marjorie Shearon, proposes the following resolution:

WHEREAS, the Harness Report of the past session of Congress returned a severe criticism and indictment of certain branches of the Federal Security Administrator's office in the misappropriation of funds for propaganda and other counts, and

WHEREAS, this Harness Report is now before the Attorney General,

THEREFORE, BE IT RESOLVED, that the Arkansas Medical Society goes on record, requesting the Representatives and Senators from the State of Arkansas to do all in their power to see that this Report receives a full and comprehensive review by this authority and action taken to protect such misappropriation of the taxpayers' funds for the propagandizing of Federal, Bureaucratic or Socialized Medicine by the Federal Security Administrator's office, and

BE IT FURTHER RESOLVED, that a copy of this Resolution be immediately forwarded to the Representatives and Senators of the State of Arkansas.

By motion (Richardson-Hunt) requested acceptance of Reference Committee's Report with the exception of the recommendation to increase Society membership assessment to \$20 January 1, 1950.

By motion (Hunt-Kolb) the annual membership assessment was increased to \$20 beginning January 1, 1950.

John H. Wilson read a supplementary report of the Council.

SUPPLEMENTARY COUNCIL REPORT

At a meeting of the Council on April 16th, the following action was taken:

(1) Authorized R. B. Robins to present the name of T. E. Rhine for nomination to the American Medical Association for the award of American General Practitioner of 1949 at the Interim Session.

(2) Recommended the appointment of J. D. Riley as director from Arkansas to the National Tuberculosis Association.

(3) Allowed the Committee for the Extension of Medical Care a \$500 fund for committee expenses.

(4) Authorized a luncheon or dinner for "Fifty-Year Club" members at future sessions of the Society.

By motion (Hoge-Hunt) the supplementary report of the Council was accepted.

Earle Hunt, chairman of the "Fifty-Year Club," presented awards to F. A. Lee and W. H. Toland.

By motion (Rush-W. J. Hunt) the House of Delegates adjourned.

FINAL GENERAL SESSION

Saturday, April 16, 1949

Immediately following adjournment of the final session, President Lutterloh called the final general session to order.

The following past-presidents were seated on

the rostrum: H. Fay H. Jones, R. B. Robins, H. King Wade, Joe F. Shuffield, M. L. Norwood, S. J. Allbright and H. T. Smith. President Euclid M. Smith received the gavel from President Lutterloh, both speaking briefly. Fount Richardson escorted President-Elect Earle H. Hunt to the rostrum and he thanked the Society for his election.

By motion (Kolb-Verser) the Society accepted the invitation of the Sebastian County Medical Society extended by A. F. Hoge and F. H. Krock, to meet in Fort Smith in 1950.

By motion (Owens-Kolb) the Annual Session 1950 will be held on Monday, Tuesday, and Wednesday, with specific dates to be selected in the future.

By motion (Brooksher-Millard) a vote of thanks was extended to everyone contributing to the success of the Seventy-third Annual Session.

By motion (Brooksher-Gray) the Society adjourned sine die.

REGISTRATION—1949 ANNUAL SESSION

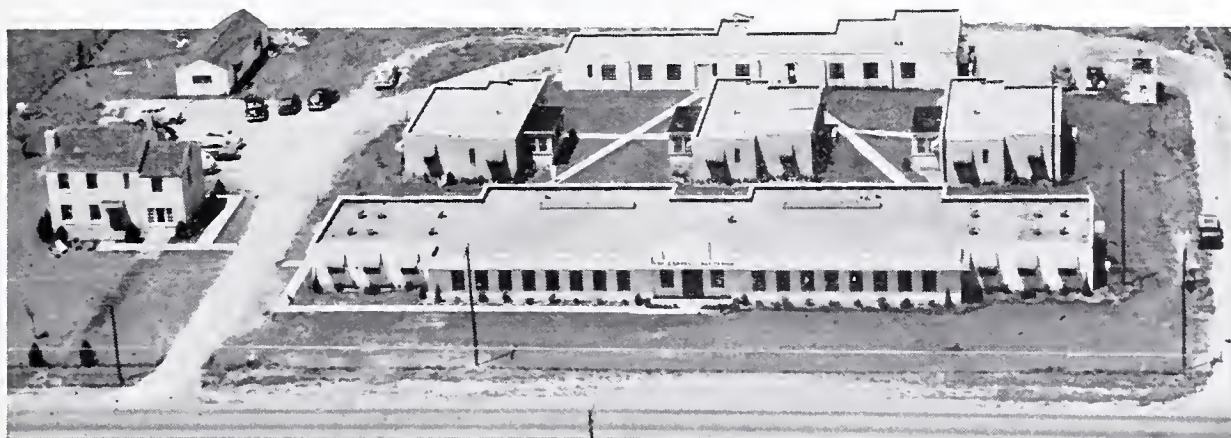
Members, 527; visitors, 35; exhibitors, 62; medical students, 147. Total, 771.

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No. 2

HEMOCHROMATOSIS: REPORT OF A CASE IN A WHITE FEMALE WITHOUT DIABETES *

CHAS. T. CHAMBERLAIN, M. D.
Fort Smith

Hemochromatosis, pigmentary cirrhosis of the liver or so-called bronze diabetes is a disease of unknown origin, generally identified as a disturbance in metabolism in which there occur the following: A marked deposition of pigments, particularly the iron containing hemosiderin, in the skin and many of the viscera; by cirrhosis of the liver and other organs, and in most cases by diabetes mellitus.

It is interesting to note that the reported incidence of this disease entity is quite variable from country to country. For example, according to Patek, in Europe it was found to account for 10-25% of cirrhosis, while in the United States it can be held responsible for only 3-10%. According to the same author, this disease is seen almost without exception in the male with an age range between 30 to 60 years. Sheldon in 1935 had collected 311 cases of which 13 were in the female. In 1942, 400 acceptable cases were found in the literature by Humphrey, Alpinier and Verity.

Numerous theories have been presented concerning the etiology of hemochromatosis. Berk, quoting Sheldon, has listed the following in brief summary groups:

- "1. Consider diabetes the primary phenomenon;
- "2. View the liver as primarily at fault;
- "3. Hold that the essential factor is destruction of blood;
- "4. Incriminate a toxin, either bacteriologic or some unknown toxic bodies or alcohol, zinc, lead, or copper;
- "5. Hold that suprarenal disease is the underlying disturbance;

- "6. Consider that the essential disorder lies in the reticulo-endothelial system as it is concerned with the metabolism of hemoglobin;
- "7. Assume that the basic disturbance is an inability on the part of the cells to reduce ferric to ferrous iron;
- "8. Suggest that the disease represents a disorder of metabolism in which the cells and tissues have an abnormal avidity for iron; and
- "9. Conclude that the disorder is the result of some congenital abnormality in the intracellular iron metabolism.

"Butt and Wilder, prompted by the experimental work of Taylor, Stiven and Reid in the production of siderosis in cats, suggested that perhaps a hypovitaminosis A during fetal life renders the intestinal mucosa defective and thereby permits the entrance of minute or excessive amounts of iron, or otherwise affects the cellular metabolism of the entire body so that iron in the individual cells is poorly and defectively metabolized.

"Sheldon and also Dry have expressed a viewpoint that seems best to fit the known facts in hemochromatosis. They consider the underlying disturbance to be an inborn error of metabolism, probably congenital, whereby iron is permitted to enter the cell but is unable for one reason or another to be excreted. The symptoms of the disease, they point out, are not due to the metabolic error itself, but rather to the secondary effects which result therefrom, particularly the cellular destruction and fibrosis induced in the various organs through the accumulation and deposition in them of the pigments involved."

To continue with a brief discussion of the outstanding pathological and clinical features as a background for the case to be presented, the normal skin pigment, melanin, is usually markedly increased in the skin but the significant pigments concerned in hemochromatosis are hemosiderin and hemofuscin. Of the two, hemosiderin is

* Read before the Seventy-third Annual Session, Arkansas Medical Society, Little Rock, April 14, 1949.

composed chiefly of iron combined with some form of protein. Its color is that of a deep brownish yellow and is found predominately in the secreting cells of the glands of external and internal secretion and their stroma, the lymph glands, in striated muscles, particularly the heart, the reticulo-endothelial system, the alveolar epithelium of the lungs, cartilage and the synovium of joints. Hemofuscin, on the other hand, varies in color from a light yellow to a dark brown and is closely related to melanin. It does not react to micro-chemical tests for iron. It is found to a slight extent in epithelial cells of glandular origin, in connective tissue where it differs from hemosiderin in that it is always intracellular. Smooth muscle throughout the body also contains this latter pigment.

The liver is usually greatly enlarged with an average weight of 2000 or 3000 gm. Grossly, the liver has a reddish or rusty hue and has a finely hobnail appearance. Microscopically, the liver may show a typical cirrhosis with hemosiderin deposits in the liver cells and in the fibrous stroma. The pancreas, usually increased in size and deeply pigmented, presents changes similar to those found in the liver. The same applies to the spleen. According to Ramage and Sheldon, the total amount of iron in the tissues varies from 25 to as much as 50 gms. in contrast to the normal of approximately 3 gms.

Clinically, the cardinal features of pigmentation, enlarged liver and spleen, diabetes and genital hypoplasia characterize the classical picture of hemochromatosis.

In this case report it is interesting to note that the observations have extended over a period of twelve years. During this interval the patient has been observed intermittently; and certain pertinent clinical and laboratory studies have been conducted.

F. W., a white unmarried female, age 43, first came under our observation in August, 1936.

Chief complaint: Abdominal distress, especially upper right quadrant, pain radiating to right scapular region.

Present illness began about 18 months before August, 1936, and was characterized by attacks of upper abdominal discomfort with belching and regurgitation of food postprandially, especially after the ingestion of eggs, greens, fresh fruit, etc. Weight loss during this interval: 25 pounds. Two months before this examination she was told that she was "yellow" and she herself noted during this time that the urine was

quite dark. Two months before she came under our observation she noted the presence of a tender swollen left ring finger and aches and pains in both knees and in the posterior cervical area. Her family physician at that time told her that she had arthritis and that the gallbladder was the focus of infection. She was subjected to non-surgical drainage on several occasions with only temporary relief.

History by systems not remarkable.

Past history indicated tonsillectomy in 1925.

Family history. Father had been told on several occasions that he had "traces" of sugar in urine. Maternal grandmother had cancer of the breast.

Menstrual history. Normal.

Physical examination revealed a well nourished intelligent white female. The skin generally presented a sallow color, but there was no definite evidence of clinical jaundice. The sclerae were discolored but not definitely icteric. On the volar surfaces of both arms at and below the elbows there were scattered but discrete areas of brownish pigmentation. Both lower extremities showed moderately advanced venous varicosities below the knees. The cardio-vascular and respiratory system appeared to be intact. Blood pressure 110/80. Tenderness was present in both the lower and upper right abdominal quadrants, especially the latter. No organs were palpable. Pelvic examination was negative. Weight was 145; height 67½ inches.

In the laboratory, urinalysis was negative except for a faint trace of albumin. Bile was not present. Blood cytology was within normal limits except for a slight microcytic anemia. Hemoglobin per cent was 75. Erythrocytes were 3,950,000. Blood Wassermann and Kahn negative. Gastric analysis showed the absence of free hydrochloric acid. Total acids were low. No histamine was given. Serum bilirubin was .2 mg.%. Fluoroscopy of stomach and duodenum revealed no intrinsic pathology. The stomach was empty in four hours. A cholecystogram done 14 hours after oral ingestion of the dye showed only a faint gallbladder shadow, which, however, disappeared completely after stimulation with the fatty meal. No opaque stones were seen, nor was there evidence of negative shadows.

A diagnosis of chronic appendicitis was made and the possibility of gallbladder pathology was considered. Exploratory laparotomy was performed under general anesthesia on August 17, 1936. A summary of Dr. F. H. Krock's operative

notes follows: "The gallbladder, stomach and duodenum were found to be normal. The liver appeared to be normal in size, color and consistency. The appendix was retrocecal, kinked and bound down by dense adhesions. The appendix was removed. The pelvis presented a few graafian follicle cysts from 2-3 mm. in diameter on the right ovary. These were punctured. The patient's postoperative course was uneventful and she was discharged from the hospital on August 27, 1936."

We did not see this patient again until July, 1942. Her chief complaint on this occasion was that of mottled areas of pigmentation scattered over the skin of the trunk and extremities, and generalized pruritis. These areas of pigmentation had been observed by her over a period of 18 months to 2 years and had been slowly increasing in depth of color as well as in size. She also complained of fatigability and lack of pep. Physical examination revealed the following: Blood pressure 130/70; pulse 80; temperature 99° F. The sclerae was discolored but not definitely icteric. There was a palpable nodule about the size of a pecan in the left lateral lobe of the thyroid. The gland generally was not enlarged. No bruit was audible. Heart and lungs were not remarkable. The abdomen presented an upper right quadrant scar which was well healed and non-tender. No organs or masses were palpable. The skin generally showed rather diffuse brownish pigmentation over the entire trunk and all extremities with more darkened areas in the region of the skin folds. Rectal examination revealed internal hemorrhoids. Pelvic examination was not done.

In the laboratory, routine urine examination was negative. Blood cytology was normal. Blood serology was negative. Non-protein nitrogen was 28.8 mg.%. Serum cholesterol was 484 mg.%. Fasting blood sugar was 99 mg.%, and one hour after breakfast 190 mg.%. Fasting urine as well as specimen voided one hour postprandially showed a negative qualitative Benedict's reaction. Icterus index was 3.4. X-ray of chest was negative except for the presence of increased bronchial markings and a cardiac silhouette which showed slight left ventricular hypertrophy. An I. V. pyelogram showed good excretory function on both sides. A small calcification was visualized just below the right sacroiliac joint, which might be contained within the right ureter. The right kidney pelvis and calices appeared slightly dilated. Films in the upright position revealed a definite drop of both kidneys.

At this point a diagnosis of hemochromatosis was considered. It was felt, however, that Addison's Disease or adrenal dysfunction had to be eliminated as possibilities. No biopsy of the skin was done at this time.

Later, in October, 1943, she consulted the Mayo Clinic. From a personal communication from Dr. E. A. Hines of that institution, the following data are summarized: "This patient represents an interesting problem. Unfortunately, we were unable to reach a definite diagnosis. Her general examination revealed findings quite similar to those found during the previous observations. The fundi oculi were negative. Fasting blood sugar, 75 mg.%. The test for liver function showed dye retention, grade I (Bromsulphalein). The basal metabolic rate was plus 6. A skin biopsy showed an increase in melanin but no iron. This finding fails to confirm a diagnosis of hemochromatosis but does not completely eliminate it. The atypical nature of the pigmentation and the normal blood pressure makes quiet remote the possibility of Addison's Disease. The long standing nature of the condition and the relatively good condition in which the patient is found seem to be factors against a diagnosis of hemochromatosis."

In the interval between 1943 and 1946 no significant changes in symptoms or signs developed, except for the fact that the generalized pigmentation slowly increased in intensity and extent, so much so that on several occasions the patient was much embarrassed by being mistaken for a mulatto. Increase in intensity of the pruritis was such that sleep was frequently interrupted and the patient experienced increased nervousness and fatigability. After initial success in controlling this distressing symptom by means of intravenous infusions of 1000 c.c. of physiological saline containing 90 c.c. of 1% procaine, this weapon eventually lost its effect. Purely by accident it was discovered that intramuscular injections of penicillin, either crystalline or procaine, were effective in controlling the pruritis of variable intervals. Therapy otherwise consisted of a dietary regime and medication usually employed in the management of atrophic hepatic cirrhosis.

In October, 1946, the patient sustained an attack of acute upper right quadrant abdominal pain, accompanied by nausea and vomiting of three days duration, requiring admission to the hospital for six days. Her course was afebrile. Physical examination showed no significant changes except for the presence of exquisite tenderness in the upper right abdominal quad-

rant. The liver and spleen were not palpable. Urinalysis was negative. Erythrocytes were 3,580,000 and hemoglobin 71%. Leukocytes were 4,700 with a normal differential. Icterus index was 2.9. A cholecystogram failed to reveal any gall-bladder shadow. X-ray of chest negative. A flat plate of the abdomen revealed no definite abnormalities. The patient was discharged on the sixth hospital day free of acute symptoms.

During the interval between November, 1946, and June, 1947, no significant changes occurred except that it was noted that the thyroid adenoma was beginning to increase slowly in size. For the first time the liver edge became palpable just below the right costal margin and was consistently tender. The patient also made the observation that she noted a definite time relationship between bouts of upper abdominal gaseous distention with eructations, increase in the depth of the pigmentation and the intensity of the pruritis. This triad of symptoms seemed to occur in waves at intervals of 3-6 weeks. There were times when she felt that the pigmentation seemed to grow less intense or lighter. She seemed to feel stronger, and have less digestive distress and less itching during these so-called remissions. The relationship may have been psychological.

In June, 1947, she reentered the hospital for removal of the thyroid adenoma under general anesthesia. Her postoperative course was uneventful. The pathological diagnosis was adenoma of the thyroid, predominately fetal in type. No abnormal pigmentation was observed by the pathologist in either the gross specimen, which measured 4 x 3.5 x 2.5 cm., or the microscopic section. Laboratory observations made during this 14-day hospital admission may be summarized as follows: Urinalysis not remarkable. Erythrocytes 3,130,000; hemoglobin 70%; leukocytes, 5,000 with 59% neutrophils, 37% lymphocytes, 4% eosinophiles; basal metabolic rate, plus 10. Icterus index was 3.9. Van den Bergh: Qualitative showed a delayed, direct reaction; quantitative .2 mg.; total protein 6.5 gms; Prothrombin time, 100% of normal; Bromsulphalein, 35% retained in 30 minutes with normal function showing less than 10% retention in 30 minutes. Urine urobilinogen positive; bilirubin negative; Bena Jones proteins: negative. Stool: Urobilin and bilirubin positive. Cephalin flocculation negative; alkaline phosphatase 23.9 Bodansky units (Normal 1.5 - 4 units). Serum cholesterol 175 mg.%. Cholesterol esters were not done.

From July, 1947, until July, 1948, patient's

course was characterized by no spectacular changes. Her weight varied only slightly from a high point of 138 in November, 1947, to a low of 131 in April, 1948. Digestive function showed the usual fluctuation in efficiency as described above. Pigmentation gradually deepened to an average intensity of light brown, especially over the exposed areas of skin. Intervals of weakness increased somewhat in frequency and intensity and assumed a relationship pattern of relief after eating, which suggested spontaneous hypoglycemic reactions. Actual jaundice became more definite as was revealed by a van den Bergh reaction on April 2, 1948, which qualitatively showed a diphasic reaction and quantitatively a reading of 1.75 mg.

In July, 1948, while visiting in Nashville, Tennessee, she consulted Dr. J. O. Manier of Vanderbilt University Medical School. From a personal communication from Dr. Manier the following prevelant observations can be made: Physical examination was essentially unchanged as compared with findings previously mentioned. The most significant study was another skin biopsy which is reported here in detail:

Tissue from arm: "The specimen consists of a small piece of skin which is elliptical in shape and measures 7 by 4 by 3 mms. It is brownish to red in color and all of the specimen was used for sectioning. Microscopic findings: On one aspect of the histological section there is seen a stratified squamous epithelium with areas of relative hyperkeratosis and varying degrees of atrophy of the prickle cell layer. The basal layer is intermittently pigmented with melanin and at times of the dendritic and prickle cells of the epidermis and in the chomatophorea in the cutis. The rete pegs are absent and in the upper portion of the cutis there is an association of hemosiderin crystals with melanin. This is confirmed by the sections stained with Mallory's potassium ferrocyanide method. There is some fatty infiltration in the lower cutis but no indications of a malignant process. Diagnosis: Hemochromatosis."

Other laboratory studies done at this time are as follows:

Urinalysis: Negative.

Blood: Total leucocytes 6,000

Total erythrocytes 3,890,000

Hemoglobin 71% or 12.07 gms.

Polymorphonuclears, segmented....66%

Polymorphonuclears, unsegmented 2%

Myelocytes 0

Monocytes 0

Eosinophiles 1%
 Basophiles 0
 Lymphocytes 31%
 Hemogram: The morphology of the red blood cells appear to be within normal limits.
 Blood sugar: 143 mgms. per 100 c.c. (2 hours after meal).
 Alkaline phosphatase. 33.7 Bodansky units.
 Blood cholesterol—212 mgms. per 100 c.c.
 Cephalin flocculation—3 plus
 Bromsulphalein—40%
 Icterus index—20 units
 Serum albumin—3.00 gms. per 100 c.c.
 Serum globulin—3.97 gms. per 100 c.c.
 Total protein—6.97 gms. per 100 c.c.
 A/G Ratio—1 to 1.3
 Bleeding time—1 minute 30 seconds
 Clotting time (tube)—12 minutes
 Retractable time—35 minutes
 Prothrombin time—13 seconds or 100% of normal
 Coagulation time—5 minutes 30 seconds (Capillary)

Stool examination:

Gross color: Light brown.
 Consistency: Hard. No parasites were seen grossly. Moderate amount of undigested food.
 Microscopic: Proved to be negative for parasites, amoeba, amoebic cysts, ova, pus and blood. Bile—trace.

Most recent physical and laboratory observations made during the first and second weeks of this month (October, 1948) are as follows:

Physical examination: Pigmentation was even more prominent than on previous occasions. Tenderness was present on palpation of the lower right abdominal quadrant. The liver edge was palpable four fingers below the right costal margin, smooth and slightly tender. The spleen was tender and palpable two fingers below the left costal margin. Percussion of liver dullness along the anterior and lateral chest wall was within normal limits. No definite evidence of free fluid within the abdominal cavity could be demonstrated.

Laboratory studies:

Urine: Negative except for the presence of urobilinogen. No sugar was present.
 Blood: Hemoglobin 71%; red cells 3,580,000; white cells 4,400; stabs 4; segmenters 61; lymphocytes 26; monocytes 7;

eosinophiles 2; no malaria observed; coagulation time 4½ minutes; bleeding time 2 minutes; blood platelets, 118, 140 per 1 cu. mm. blood; undulant fever negative; cholesterol 252 mg.; non-protein nitrogen 23 mgs.; total protein 8 gms., serum albumin 4 gms., serum globulin 4 gms., ratio 1.1.

Indirect van den Bergh—3 mg. bilirubin per 100 c.c. of serum

Direct van den Bergh—biphasic reaction

Cephalin flocculation: 4 plus in 24 hours.

Glucose tolerance—fasting 91 mg. 100 grams glucose given

Thirty minutes 192 mg.

One hour 187 mg.

Two hours 134 mg.

Three hours 78 mg.

All urine specimens negative for sugar and acetone.

Interestingly enough, the patient experienced a moderately severe hypoglycemic reaction without loss of consciousness about four hours after the ingestion of the glucose meal.

In conclusion, this case problem to date presents several interesting features:

- (1) Its clinical longevity and the opportunity to make comparative observations over a period of twelve years to date.
- (2) The absence thus far of clinical diabetes mellitus.
- (3) The intense and persistent pruritis.
- (4) The relatively delayed hepatomegaly and splenomegaly.
- (5) The absence to date of any clinical evidence of mechanical block in the portal circulation.

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PARTICIPATING PHYSICIANS AGREEMENTS

As a part of the educational program of the American medical profession, emphasis is placed upon the extension of voluntary medical prepayment plans. In Arkansas Blue Cross-Blue Shield operates as Arkansas Medical and Hospital Service, Inc. Voluntary health insurance is the answer of the profession to compulsory health insurance and it is most important that our plan of voluntary prepayment care be made available to the people of the United States in an expeditious manner.

The profession has been slow in signing the participating physicians contract. The program can operate in Arkansas only with the full support of the members of the Arkansas Medical Society and it is essential that a great majority of our members sign the participating contract without further delay.

If you have not as yet signed the contract please write Arkansas Medical and Hospital Service, Inc., Waldon Building, Little Rock, for the proper form and assist in the program of extending voluntary prepayment care to the citizens of Arkansas.

"THE DOCTOR AS A CITIZEN" *

R. B. ROBINS, M. D., Camden
President, Arkansas Academy of General Practice

I want to take this opportunity to thank you for giving me the honor of serving as the first president of the Arkansas Academy of General Practice. You and I are proud of the fact that we are counted among the first members of this rapidly growing organization which is destined to be the second largest medical organization in America—second only to the American Medical Association.

It is amazing that in its first year the American Academy of General Practice recruited a membership of around 10,000 and that there was an attendance of 3,500 at its first annual meeting in Cincinnati last month (March 6-9).

The general practitioner is the backbone of American medicine. He is the most important combat soldier in the medical army. The duties and privileges incumbent upon a citizen of this greatest nation in the world are tremendous. The duties and privileges offered a citizen-doctor are great also. We are commissioned by the people of the United States to be captains of the guard in a never-ending war against disease. We are guardians of the nation's health. In our hands alone rests the success or failure of America's never-ending struggle for an ever-increasing high standard of medical care.

Generation after generation of our fellow-Americans have looked to us for preventive care, for a consistent, day by day increase of effectiveness in the treatment of sickness. The American patient is the first to testify that we have done and are continuing to do a good job. The American Medical Profession has proven itself the most progressive, the most scientifically creative medical body the world has ever known. The American people are fully aware of this, and the American people are satisfied to leave present and future health problems in the hands of medical men, where those problems belong.

But too often, as we all know, American citizens as well as citizen-doctors find themselves too busy with everyday problems to pause and take stock of potential dangers to the American way of life. Quite often we find ourselves so engrossed in daily problems that we find it difficult to believe, in our awareness that we are doing a good job, that destructive elements might be planning to attack the very foundation of

* Address given Wednesday afternoon, April 13, 1949, before the Arkansas Chapter of the American Academy of General Practice, Marion Hotel, Little Rock.

the American institution which we are pledged and committed to protect. Such an attack, directed at free enterprise in American medicine and designed to subject the health of the nation to political control, is in fact upon us. Agencies of our own government are attempting today to force upon the American people a government-controlled, politically-dominated program of compulsory federal health insurance—a plan replete with a medical dictator who would decide the amounts and quality of medical care which each American should receive. **These agencies, spearheaded by Federal Security Administrator, Oscar R. Ewing, are diverting portions of their regular congressionally authorized monetary appropriations in order to promote this plan for socialized medicine in America.**

My friends, we are meeting at a fateful hour. Today, the doctors of this country are in the front lines of one of the most critical internal struggles in the nation's history. And this is more than a fight to preserve America's high standards of medical care. The broad lines are drawn in this battle. This is a basic struggle between two warring philosophies of government and economics. It is a fight between the principles of private initiative and free economy, on one side, and the fallacies of socialism and communism on the other.

As I have said before, in this struggle the general practitioner is the most important combat soldier in the medical army. On you, more than any other medical group, depends the outcome of this fight. You are not only the main line of defense; you are also the most powerful shock troops in medicine's affirmative campaign of public education.

It behooves you to take a keen interest in political affairs. Democracy functions through politics as you well know. It is inconsistent of us to criticize actions of politicians, while we ourselves evade political service or interest in political affairs.

Doctors have a tremendous political potential with their patients and friends, but it is seldom used. It is too generally regarded that political activity is a dirty game and beneath the dignity of a professional man. When we find politics dirty, it is so just because of this attitude on the part of self-respecting people. They permit it; otherwise it would not be so.

One of our recent presidents of the American Medical Association, Dr. Edwards Bortz, appealed to doctors to take up the duties of statesmen. The traits of patients, understanding and perseverance that are to be found almost always in

a successful doctor are likewise needed in politicians and statesmen. Too often they are lacking.

In former years we had more doctors in public life than we have today. Six doctors signed the Declaration of Independence and three signed the Constitution of the United States. Sun Yat Sen, the first president of China, was a physician. General Leonard Wood, a great military leader, was a physician, as was Clemenceau, who led the French nation through the first World War. William Henry Harrison, one of our presidents, was at one time a student of medicine. The Secretary of Interior in President Hoover's cabinet was Dr. Ray Lyman Wilbur, who was president of the American Medical Association in 1923. The Secretary of Interior for President Coolidge was Dr. Hubert Work who was another president of the American Medical Association (1921).

The roster of medical men, who have been distinguished in the political life of this and other countries, would include many of the great names of history.

Doctors probably don't take as active a part in political affairs today as formerly, because of the fact that medicine is a more exacting and time-consuming task than formerly. In the last Congress there were seven doctors and two dentists in the House of Representatives and none in the Senate; in the present Congress there are eight doctors and two dentists in the House of Representatives and one dentist in the Senate.

Doctors have tremendous obligations as citizens. They need to take part in helping a sick society to recover and in the creation of a more stable society. Physicians are as capable of knowing human needs and of understanding human relations as any other group in our society. It behooves our medical men to be good citizens as well as good doctors. Interest in public affairs today is a major responsibility of the medical profession since there is so much at stake.

It is difficult to understand why social reformers and politicians are trying at this moment to import into healthy America a plan from sick Europe, when America leads the world in medical science today. Health progress in America exceeds that of any country in the world. **Our country ranks first in the world in life expectancy. A child born in this country in 1900 could expect to live 49 years; today he can expect to live 68 years. We have more doctors according to population than any other country. There is one doctor for every 710 people in our country;**

England is next with one doctor to 870 people.

People in our country spend four times as much on luxuries and non-essentials as they do on medical care. In 1947 the total cost of medical care (including drugs, dentistry, hospital care and physicians' bills) was 6.5 billion dollars, yet in that same year they spent 9.6 billion for alcoholic beverages, 9.2 billion for recreation, 3.9 billion for tobacco, 1.5 billion for jewelry and 2.3 billion for personal care (cosmetics, etc.).

The plan of the social reformers and Mr. Ewing to socialize medicine in this country would come at a very high price to the tax-payers of the United States. Using figures for cost of medical care in the **Veterans Administration, it has been shown that the anticipated cost of complete medical care for the entire nation would be over 18 billion dollars.** This corresponds to a **10% tax on the annual payroll of 180 billion dollars.** Today the thing that is worrying the average American family is not the medical bill; it is the tax bill.

Voluntary health insurance, which is being carried now by **one-third** of the **population** and increasing daily, is much less expensive. For the price of a package of cigarettes a day, a family can carry splendid voluntary health insurance. In the face of the figures I have just given you regarding the cost of compulsory government insurance, I present this question: If people cannot afford Voluntary insurance, then how on earth can they afford the expensive compulsory government health insurance?

Any type of compulsory federal health insurance or socialized medicine would create a tremendous federal bureaucracy—a huge administrative staff. In Germany, there was one administrative employee for each 100 persons insured. Our recent Hoover report shows that our Veterans Administration today has one employee to each 97 of its 18 million beneficiaries. So a socialized medicine scheme in America would call for a bureau of **1.5 million employees to run it.** The Hoover report shows us how wasteful and how very expensive government control of medical care actually is. The Hoover report reveals that the hospital stay per patient is four times as long in a government hospital as it is in a private hospital. The average stay per patient in private hospitals is **7 days** and in federal hospitals it is **30 days.**

Considering the possibility of the adoption of a socialized medicine program for America with its cost to the tax-payers of 18 billion dollars per year, arouses in us serious thought to its relationship to our economy as a whole. Our

national debt is still over 252 billion dollars, which means that **each person in our country owes \$1,700;** it seems to me that in view of these facts it would be very unwise to undertake such a costly experiment as socialized medicine.

There is nothing that the government can do for the citizen in the field of health insurance that the citizen cannot do better for himself and at far less expense.

A few days ago (March 30) Senator Hill, for himself and Senators O'Connor (D., Md.), Withers (D., Ky.), Aiken (R., Vt.) and Morse (R., Oreg.), introduced S.1456. Senator Hill had the advice of Dr. Gilson Colby Engel, president of the Pennsylvania State Medical Society, and of Dr. Paul Magnuson of the Veterans Administration.

The bill is called the Voluntary Insurance act. The bill proposes allocation of federal funds to the individual states, such funds to be matched by state funds, and to be used by the state authority for the purchase of voluntary hospitalization and sickness insurance policies for persons unable to pay the costs of medical care in whole or in part. This bill has many splendid features and corresponds with many of the principles of the 12-point program of the American Medical Association. The attitude of the American Medical Association toward this bill will not be known until the House of Delegates of the American Medical Association takes official action at its meeting in June in Atlantic City.

The bill will stimulate enrollment in Blue Cross and Blue Shield, but it makes no provision for people who would prefer to purchase commercial insurance. This provision would make government agencies the promoters of Blue Cross-Blue Shield. We must give consideration to this question. Would this bill pave the way for the capture of the voluntary insurance movement by the government?

Under the plan the government, through the Veterans Administration and the Public Health Service, could buy Blue Cross-Blue Shield policies for all its beneficiaries. This would give the government a big stick in running the voluntary insurance plans.

As soon as this plan went into effect, there would be immediately urged the formation of a national insurance company rather than have, as we do at present, plans run on a state level. If Blue Cross-Blue Shield should bog down and fail on a national basis, then the government would step in and take over.

We must give this bill serious study before we accept it or condemn it. It is offered as a sub-

stitute for the national compulsory health insurance plan demanded by President Truman. It is a different approach to the problem and is certainly worthy of our serious study.

In closing, my friends, I want to call your attention to the fact that in your home communities, each of you is a symbol of free American medicine. As a doctor-citizen you have it especially within your power now to play a major part in saving our American Way of Life.

INTERNATIONAL AND FOURTH AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

The American Committee on Maternal Welfare, which was organized over ten years ago by a group of people interested in improving maternity care, announces the International and Fourth American Congress on Obstetrics and Gynecology to be held May 14th to 19th, 1950, at Hotel Statler (formerly Pennsylvania Hotel), New York City.

Under the chairmanship of Dr. H. C. Taylor, Jr., of New York, the General Program Committee has set up a program of special interest to the general practitioner. The morning sessions would be devoted to one of five topics:

1. Physiology of Human Reproduction
2. The Pathology of Human Reproduction
3. Social and Economic Problems
4. Neoplastic Diseases of the Female Reproductive System
5. Obstretic and Gynecologic Procedures.

The afternoon sessions will be given over to the various groups represented at the Congress, nurses, nurse-midwives, hospital administrators, educators, practicing physicians, investigators in special fields and public health workers. There will also be scientific and technical exhibits.

Those who attended any one of the previous Congresses will recall that the papers and exhibits were of a special value to all interested in improving maternal health.

It is not too early to make plans for attending this Congress where the leading obstetricians and gynecologists of foreign countries will present papers of interest to the care of mothers and babies.

Membership in the American Committee is open to all who are interested in maternal welfare should take out their 1949 memberships now. The dues are \$5.00 for 1949 and can be sent direct to the headquarters of the American Committee on Maternal Welfare, Inc., 24 West Ohio Street, Chicago 10, Illinois.

CORRESPONDENCE

June 18, 1949

Dr. W. R. Brooksher
National Bank Building
Fort Smith, Arkansas
Dear Doctor:

In the June issue of the Journal of the Arkansas Medical Society, we ran an ad on one of the center pages, on the new Keleket 250 KVP 15 M.A. therapy unit. Up above this ad we inserted a notice that this machine had been recently installed at the University of Arkansas Medical School, Little Rock, Arkansas, and at the Davis Hospital Tumor Clinic, Pine Bluff, Arkansas.

I have just been called down by Dr. Fred Hames, of Pine Bluff, and I realize that we should have said that this machine was installed at the Davis Hospital Tumor Clinic, Pine Bluff, but that it was the sole property and was operated by Dr. Fred Hames of Pine Bluff, Arkansas.

Would you kindly correct this statement for us in one of your notices, or in some place in the Journal, so Dr. Hames will see this in the next issue. I am naturally very sorry about this error, and would like to give credit where credit is due. So if you could find some place in your fine Journal to correct this announcement, I would personally appreciate it very much. It would of course get me out of the dog house with Dr. Hames, and with my company.

Thanking you in advance for this and your many past favors, and much fine business, I am

Very truly yours,

WM. T. STOVER CO., INC.

G. Dan Cummings

Mgr., X-ray Department

MEDICAL SCHOOL UNITES CLINICS

The University of Arkansas School of Medicine this month united the Obstetric-Gynecologic Clinic into a single unit. Colored obstetric or gynecologic patients should register by 8:00 A.M., Monday, Wednesday or Friday. White obstetric or gynecologic patients are to register by 8:00 A.M. on Tuesday or Thursday. If referring physicians will adhere to this schedule, it will do much to further efficiency of the out-patient department.



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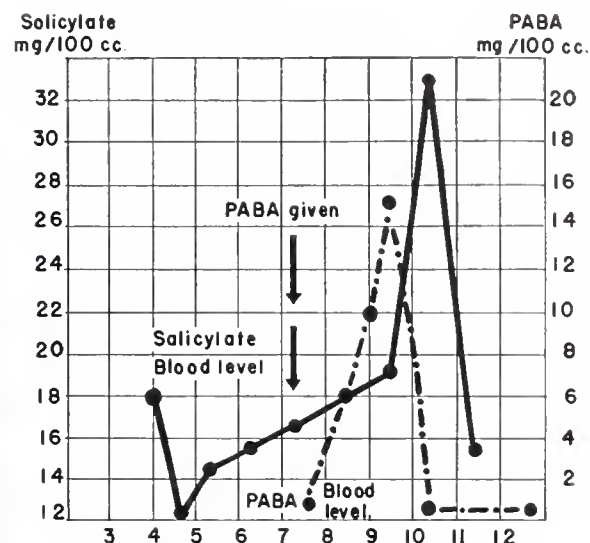
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EDITORIAL

American Medical Association Campaign "Deserves Prize for Honesty of Purpose"

Says Chicago Journal of Commerce

"CONTRASTS IN METHODS"

(Editorial Reprinted from Chicago Journal of
Commerce, June 2, 1949)

The American Medical Association has done an unusual thing!

In order to combat misrepresentation of the purposes and methods of its publicity campaign against compulsory federal health insurance, AMA has sent to every member of the 81st Congress a complete, booklet-form breakdown of the association's plan of action.

Prepared by Whitaker & Baxter, the public relations firm which is directing the AMA's drive, the booklet carefully blueprints every step to be taken at the county, state and national level.

If members of Congress take the time to read the plan, AMA's professional and lay critics will

be wasting their time when they charge the organized doctors with sly, unethical propaganda.

Compare this candid, open position with the statements of Acting Security Administrator J. D. Kingsley when that gentleman testified recently before a Senate committee.

Mr. Kingsley testified that Mr. Truman's compulsory health insurance program would cost \$5,600,000,000.

If the administration were half as frank as the AMA directors, it would instruct all its witnesses to tell Congress that all cost estimates are at best only informed guesses—and not too well informed at that.

No similar system anywhere ever has remained for more than a year at most within the original estimate. The cumulative costs of such schemes cannot be estimated.

Mr. Kingsley also played a variation of the President's theme that existing voluntary health insurance plans "have proved inadequate." These plans, said the acting security administrator, cover only some 32,000,000 people "with limited hospital care only." His general conclusion was that voluntary health insurance costs too much for most people and cannot pay its way on lower premiums.

That statement of the case is considerably less than frank. What Mr. Kingsley did not tell Congress, for example, was that the Blue Cross insurance plan was not established until 1934. During 15 years it has had the phenomenal growth of more than 2,000,000 members a year.

Nor is it true that private plans provide for hospital care only. We now have Blue Shield which insures its members on actual medical service provided by doctors and surgeons. Blue Shield, which has had a somewhat slower acceptance than Blue Cross (largely for the reason that hospital care is usually a much heavier burden of illness than the doctor's bill) nevertheless now has some 10,000,000 members and is growing daily.

The AMA proposes to sell the American people on the idea that voluntary health insurance is preferable in every way to a compulsory scheme administered by government through state and local officials.

The federal government, which ought to be encouraging Americans to provide for their own care from their own incomes, instead belittles private insurance plans by telling Congress that such programs are inadequate.

Actually, in this controversy, the American

Medical Association seeks to preserve the traditional American way as opposed to a federal administration trying its best to destroy that way.

If the nation's press intends to give any prizes for honesty of purpose in this battle of words, let them go to the AMA.

CAUTION! BROKEN FLUORESCENT TUBES

Because an inside coating present in fluorescent lamps contains beryllium, the handling of broken tubes constitutes a health hazard. Beryllium has been found to cause chronic inflammation, to delay the healing of wounds and to produce tumor-like growths, and, if inhaled in sufficient quantity, will cause inflammation and injury to the lung parenchyma.

Great care should be taken in disposing of old fluorescent lamp tubes. They should not be placed in the home incinerator but should be placed under water in a protective covering, if possible, and broken, or buried. Should such a tube be accidentally broken all exposed areas of the skin should be thoroughly washed and the contaminated clothing should be removed.

Manufacturers are working on a new compound which will eliminate this hazard and while this will solve the problem in time, present tubes are not free of hazard.

RANDOM THOUGHTS OF THE SECRETARY

May 28th. By the comfortable Rocket to Little Rock where the husband of the Auxiliary president and Nancy pick us up for the ride to the Hundley home and we become guests in the grand manner for the evening.

May 29th. About the city with the Hundleys this morning and then to Hames' country home where the radiologists gather in social session for the afternoon and thence with the Meschans back to Little Rock and later aboard the night train into Booneville, retrieving our car at Paul McConnell's house and heading homeward with the dawn.

June 1st. Never did a spontaneous delivery occur on an X-ray table of ours until this morning and great is the excitement among the technicians.

June 4th. With Bob and Margaret Robins from Saint Louis by way of Louisville, Charleston, Washington and, a tip of the hat in full sweep to Eastern Airlines, which makes an unscheduled stop at Atlantic City this afternoon to unload some thirty physicians whose flights are thus uninterrupted by the bother of changing planes at Washington.

June 5th. Giving the day to the radiologists in business session and because of such commitments not permitted to hear Arkansas's McClellan tonight but pleased

at the compliments given him, all agreeing that his views on medical care are sincere and in the best interests of the American people.

June 6th. The House of Delegates goes in session and this deliberative body gets ready for much discussion and decision. Our reference committee comes up with recommendations, the House approving but two. In the evening representing the American College of Radiology at the banquet of the American Radium Society, a beautiful function well-handled by President Lenz and we wonder where Goldstein might be on such an occasion.

June 7th. The House of Delegates deliberates its problems greater by the year with the solution evasive in all respects. Tonight Phillip Morris entertains in gracious manner with the vaudeville of Palace caliber and most fascinating. We introduce 3-H Hundley to Johnny of Phillip Morris, neither being impressed with the other's fame.

June 8th. Visiting the Auditorium and its exhibits and we wonder when these sample-toting folks will bring grocery hampers to carry home the loot. Impressed by the exceptional Scott and White Clinic exhibit, a marvel both in scientific presentation and mechanical excellence. To the section on radiology in the afternoon and it would not appear that thirty cases of gastric malignancy in a 1200 series warrants any marked observations on the differentiation of benign and malignant lesions and that is what the discussant said in soft answer. Tonight we entertain the Oklahoma delegation and President Smith and the pleasure of these fine gentlemen is all ours although we think Jimmie Latz of the renowned Knife and Fork had his bit of fun as well.

June 9th. Come some 25 Arkansans for the Arkansas breakfast, a delightful function which is about to become a tradition, and then dispersing the each of us to the program of the day. For the Arkansas delegates this involves attendance with intent interest as the report of the second reference committee on "national school health services legislation," an item apparently of moment only to Arkansas physicians although why no one else cannot read "compulsory medical care" in its pages is beyond us. Strangely enough, we are again forced to plead our views and, Thanks Be, the House of Delegates again votes with us and we sit down conscious of a hard and difficult campaign in which our views have finally been upheld despite disinterest when there might have been more sympathy.

June 10th. From Washington airport in a routine flight, smoother than usual for this airline to Little Rock, where our ship is detoured down an alley, there being some distinguished group alighting at the appointed place and commoners can not be about it seems.

June 17th. Over the Boston mountain range with Saint Paul, Pettigrew, Kingston, the White and the King rivers as landmarks but little else other than farms perched on hill sides to Harrison and astounded at the Sunday appearance of downtown streets, a mystery which is explained on landing when we are told that parking meters were installed this week. Meeting with the Ninth Councilor District society which hears the interesting presentations of President Smith and of Growdon, Brown and Dean of the medical school faculty. Departing prior to the postmortems with some financial return to the society and to the educational campaign sorry that we could not visit longer and back to work again after a lapse of but five hours, three spent at the meeting, a plug for air travel.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE screening of large numbers of people for tuberculosis by the use of chest X-rays has resulted in an appreciable number of cases of primary carcinoma of the lung being found at a stage in which surgical intervention may be effective. As with tuberculosis, prompt detection and treatment before symptoms appear give the greatest hope for complete recovery.

CANCER OF THE LUNG

Cancer of the lung, its detection and treatment, is so closely linked to the modern attack upon tuberculosis that every physician and surgeon, every social worker and educator, interested in the latter disease should likewise be well informed about primary cancer of the lung. Many skilled observers believe that this disease actually is increasing in incidence; others argue that it is merely being identified more accurately in recent decades. All agree that it is one of the most frequently encountered and one of the most important types of malignant disease encountered in the male sex, probably second only to cancer of the stomach.

There is no explanation for the remarkable fact that primary cancer of the lung is six to eight times as common in men as it is in women. Its amazing frequency among miners working with radioactive materials in certain German mines may be significant to the coming age of atomic warfare and atomic power. Its possible relationship to potentially carcinogenic agents in road building materials and exhaust products of internal combustion motors has been questioned and denied. The actual causes of cancer of the lung are as obscure as are the causes of other types of malignant growth.

The effective surgical treatment of primary cancer of the lung has developed largely within the past 10 years, aided by new techniques and by the protective value of modern antibiotics. Many surgeons received their special training and experience in thoracic surgery during the recent war and hence the availability of such treatment has been greatly increased within the past five years. Surgical mortality rates are still declining steadily, so that exploration of the chest can be performed almost as freely and almost as safely as surgical exploration of the abdomen.

Chemotherapy of cancer has not yet come of age but steady progress has been recorded in

recent years and never before have so many diligent and skilled scientists devoted so much energy to a medical problem. Indeed no previous medical problem could be more significant to the human race.

As with other cancers, early diagnosis is of paramount importance; and, as with other pulmonary diseases, X-ray examination of healthy persons and of those with early respiratory symptoms is the most useful screening procedure. However, early cancers of the lung often cast indefinite or confusing shadows upon X-ray films, simulating tuberculosis, pneumonia, lung abscess or almost any other type of localized pulmonary infiltration. Bronchoscopy will reveal the early cancers which originate in larger bronchi, especially those of the lower lobes of the lungs. Recently the microscopic examination of sputum for cancer cells has gained in accuracy and in popularity, but few trained diagnosticians in this difficult technique of examination are available today.

Every large chest X-ray survey project brings to light cases of primary cancer of the lung, and these may prove to be the most readily curable if detected and treated before symptoms have developed and before the disease has proceeded to an inoperable stage. Some of these cases have been referred to tuberculosis sanatoriums under erroneous diagnosis or for observational purposes. Sanatorium physicians are learning to view with suspicion any localized pulmonary lesion, especially if somewhat circumscribed and progressive and if tubercle bacilli cannot be demonstrated.

Modern cultural techniques for isolating tubercle bacilli are sufficiently accurate that negative examinations of secretions have real value in excluding tuberculosis and in increasing the suspicion of cancer. But occasionally the shadow cast by X-ray is sufficiently suggestive of cancer,

even when the lesion is small, to justify exploratory surgery without awaiting the prolonged incubation of cultures. As with all other medical decisions which affect the life of the patient, the physician must have the skill and experience to balance the risk of early radical action against the sometimes greater risk of delay and observation. Whether or not a curative operation can be performed may depend upon whether it is done within the first few weeks after detection of a lesion.

Physicians in general practice and specialists in internal medicine are learning that repeated attacks of pneumonia may actually be obstructive pneumonitis caused by the blocking effect of a bronchial cancer, and that symptoms may be relieved promptly but only temporarily by penicillin treatment. They have learned that every case of pneumonia should be studied by X-ray and followed by repeated films until the possibility of an obstructing cancer is excluded. The expectoration of blood is more typical of cancer than it is of tuberculosis. Wheezing respiration caused by an obstructing bronchial cancer may simulate asthma for a few weeks or months. Pleurisy caused by cancer extending to the pleural surface of the lung may at first simulate the pleurisy of tuberculosis or of pneumonia.

The campaign against cancer, like the campaign against tuberculosis, must depend upon an enlightened public, a skillful and alert medical profession, and an inspired corps of scientific investigators. The universal use of X-ray, almost to the point of apparent extravagance, would seem to be required if any large proportion of cases of cancer of the lung are to be detected in time to permit curative treatment by present-day methods.

Cancer of the Lung, H. Corwin Hinshaw, M.D., The NTA Bulletin, February, 1949.

WOMAN'S AUXILIARY NEWS

The regular monthly meeting of the Woman's Auxiliary to the Craighead-Poinsett Medical Society met on June 2 at the Jonesboro Country Club. After dinner with the doctors the ladies withdrew to another room for a business session with Mr. G. M. Kinzer, President, presiding. Minutes of the April meeting were read and approved. The Secretary also read a letter dated April 28, 1949, from the Federal Security Agency which acknowledged the Auxiliary's letter to the White House containing resolutions adopted by the Auxiliary concerning President Truman's plans for national health insurance.

The president announced various committees for the year.

Nine members and three guests—Mrs. Dan Fisher and Mrs. Carruthers Love of Memphis, and Mrs. J. W. Ramsey of Jonesboro, were present.

There being no further business the meeting was adjourned.

Mrs. Malcolm O. Peeler,
Publicity Chairman.

Mrs. C. E. Kitchens and Mrs. W. L. Kitchens were hostesses at the May meeting of the Bowie-Miller County Medical Auxiliary. The meeting, held Friday morning, May 27, at the home of Mrs. W. L. Kitchens, was attended by 20 members.

Preceding the business session, refreshments were served from a beautifully appointed serving table.

Mrs. Roy Baskett, retiring president, opened the business meeting and following the invocation, introduced Mrs. J. T. Robison who installed the officers for 1949-50. They are Mrs. A. A. Little, president; Mrs. N. W. Peacock, president-elect; Mrs. R. R. Kirkpatrick, first vice-president; Mrs. Brooks Tate, second vice-president; Mrs. J. C. Ferris, third vice-president; Mrs. J. W. Jones, recording secretary; Mrs. E. T. Ellison, corresponding secretary; Mrs. Richard Brunazzi, treasurer; Mrs. P. H. Phillips, parliamentarian; Mrs. L. H. Lanier, historian; Mrs. Cyrus P. Klein, publicity secretary; and Mrs. J. T. Robison, chaplain.

Following installation of the new officers, Mrs. Little appointed committees who will function for the coming year.

It was announced that the June meeting would be a family picnic to be held at the country home of Dr. and Mrs. Allen Collom.

Mrs. Cyrus P. Klein,
Publicity Chairman,
Bowie-Miller County Auxiliary,
Texarkana, Arkansas.

The Woman's Auxiliary to the Arkansas Medical Society was honored to have as guests at the 25th annual meeting held in Little Rock, April 14-16, Mrs. Joseph W. Kelso, President, Woman's Auxiliary to the Southern Medical Association, Oklahoma City, Okla. Mrs. Luther H. Kice, President, Woman's Auxiliary to the American Medical Association, Long Island, N. Y., and Mrs. Arthur A. Herold, National Treasurer, Shreveport, La.

PERSONALS AND NEWS ITEMS

The State Medical Board of the Arkansas Medical Society has elected the following officers: W. H. Poynor, Harrison, president; Chas. H. Lutterloh, Hot Springs National Park, vice-president, and Joe Verser, Harrisburg, secretary-treasurer.

Harvey Shipp and C. Lewis Hyatt, Little Rock, attended the Atlantic City session of the American College of Chest Physicians.

J. Harry Hayes, Little Rock, attended the American Goitre Association at Madison, Wisconsin, during June.

Dr. and Mrs. Chas. T. Chamberlain, Fort Smith, spent a June vacation in the Canadian Rockies and on the west coast.

BORN—To Dr. and Mrs. A. S. Koenig, Fort Smith, a daughter, Gretchen Marie, on June 18th.

D. A. Rhinehart, Little Rock, presented the Jerman Memorial Lecture to the American Society of X-ray Technicians at San Francisco June 9th. His subject was: "This Thing Called Atom."

Paul L. Mahoney, Little Rock, attended the course in rhinoplastic and otoplastic surgery conducted by the Fomon Clinic at Los Angeles during June.

Edwin C. Gray, Little Rock, was elected a Fellow of the American College of Radiology at the Atlantic City session.

R. B. Robins, Camden, discussed the paper, "Juandice" by Phil Thorek, Chicago, before the Section of General Practice, American Medical Association, Atlantic City.

W. R. Brooksher, Fort Smith, was elected vice-president of the American College of Radiology at the Atlantic City session June 5th.

Art B. Martin has returned to practice at Fort Smith after one year's postgraduate study at the University of Pennsylvania.

BORN—On May 23rd, a son, William James II, to Dr. and Mrs. W. J. Stocker, Fayetteville.

Ralph E. Crigler, Fort Smith, addressed the

recent session of the American Proctologic Society at Columbus, Ohio, on "Sodium Pentothal Anesthesia in Ano-Rectal Surgery: An Analysis of 1500 Cases." M. S. Craig, Jr., and Hoyt R. Allen, Little Rock, also attended the session and Dr. Craig was elected to membership.

Earl Parsons, Jr., Little Rock, received the degree of fellowship from the American Psychiatric Association at its recent meeting in Montreal.

Diagnostic cancer clinics under the joint sponsorship of the county medical society and the Arkansas Division, American Cancer Society, were conducted during May as follows: Walnut Ridge, R. H. Willett; DeWitt, Fred Hames; Eureka Springs, S. W. Hawkins and J. D. Olson, and Waldron, D. W. Goldstein, T. P. Foltz and W. R. Brooksher.

Euclid M. Smith, Hot Springs National Park, attended the International Congress on Rheumatic Diseases in New York City, the American Therapeutic Society at Atlantic City, and the American Medical Association at Atlantic City during June.

Peter W. Koenig has moved from Mulberry to Alma.

Fred Hames, Pine Bluff, conducted a diagnostic cancer clinic at Yellville June 15th.

G. M. Kinzer has been elected treasurer of the Caraway Lions Club.

E. J. Horner has been elected surgeon of the Jonesboro post, American Legion.

H. W. Thomas, Dermott, spent a recent vacation at Dunnellon, Florida.

The following were registered at the Atlantic City session of the American Medical Association: O. W. Beard, Little Rock; W. R. Brooksher, Fort Smith; T. Duell Brown, Little Rock; G. E. Cannon, Hope; G. C. Coffey, Hot Springs National Park; Eva F. Dodge, Little Rock; D. W. Goldstein, Fort Smith; D. C. Lee, Hot Springs National Park; J. S. Levy, Little Rock; E. S. Kerekes, Little Rock; O. J. Kirksey, Mulberry; E. J. Munn, El Dorado; N. W. Peacock, Ashdown; R. B. Robins, Camden; Howard Schwander, Little Rock; Euclid M. Smith, Hot Springs National Park, and L. A. Whittaker, Fort Smith.



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The difficulties and pitfalls in diagnosing amebiasis are stressed frequently in medical literature.

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1. Warshawsky, H.; Nolan, D. E., and Abramson, W.: Hepatic Complications of Amebiasis, *New England J. Med.* 235:678 (Nov. 7) 1946.

2. Manson-Bahr, P.: Some Tropical Diseases in General Practice: “A Post-War Legacy,” *Glasgow M. J.* 27:123 (May) 1946.

PROCEEDINGS OF SOCIETIES

The Ninth Councilor District Medical Society met at Harrison June 17th for the following program: "Report on the 1949 Session of the American Medical Association," Euclid M. Smith, Hot Springs National Park; Presentation of the motion picture, "The Early Diagnosis of Cancer," James Growdon, Little Rock; "Management of Breech Delivery," W. E. Brown, Little Rock, and "Unusual Surgical Cases," Gilbert O. Dean, Little Rock.

The Pulaski County Medical Society met June 13th for a program on "Pain in Neck and Shoulders" with the following participants: Orthopedic, S. B. Thompson; Neurologic, Robert Watson; Roentgenologic, D. A. Rhinehart, and Summary and Conclusions, Jos. F. Shuffield.

CORRESPONDENCE

May 11, 1949

To the Journal of the Arkansas Medical Society, Fort Smith, Ark.

Having practiced medicine more than 50 years, I have had an opportunity to make some important observations as to the trend of certain diseases. Some diseases that were very prevalent 50 years ago are almost extinct today through the administration of prophylactic treatment. However, some other diseases are on the increase, mainly heart disease or heart conditions. I have for many years given the heart some special study. I have not posed as a so-called heart specialist but to try to know as much as possible about this important organ, so that I could feel to some extent competent to treat those who fell into my hands.

Due to the alarming increase in deaths attributed to heart failures I am constrained to offer my opinion as to why this is true. I know that state and national heart associations have been organized to study and find the cause and remedy for this unseen killer. Of course I feel that it is a problem for the medical profession to solve but I am skeptical as to any good that may result from organizations for this purpose. To me the cause is plainly before us, and the treatment for a great number of them will not be given. They will not live long enough to take treatment. If they do survive the first attack they are rarely ever able to work again. Whether these cases are all due to coronary occlusion, I am not sure. A large majority no doubt are. There have been but few post-mortems made in these cases and

for this reason we are not sure of the pathology.

Now for the cause of this constant growing increase in heart failure. I am thoroughly convinced it is due to our modern way of living. Ever since we left our horse and buggy days and began our rapid way of transportation by automobile and airplane, the heart failures have increased by leaps and bounds. In my opinion it is due to constant stress and nerve tension which keeps the heart racing from 20 to 50 times faster per minute than nature intended it run. It will stand this for a short time like a foot race and return again to normal without injury, but when kept at a rapid rate for 15 to 20 hours per day every day, it will certainly wear out much too soon.

In our opinion the greater part we physicians can play in this crisis is prevention by and through the most impressive plans possible we should teach our people the necessity of relaxation and the necessity of 8 hours sleep in every 24 hours, how to eat and how not to eat, or drink and to make it imperative to go to a competent physician for a check-up every 30 days, also their advice. This advice should impress the patient of the peril of overtaxing his energy, overeating, and overdrinking, and last but not least, slower driving. Today the great race of mankind to succeed in business, to beat his competitor to the goal. He races his high-powered automobile at 80 miles per hour with his mind so absorbed in his business that he may meet his accidental death on the highway or he may reach his destination only to die of heart failure. The difference between the activities of mankind today and 50 years ago, spells the difference in the number of heart failures then and now. I have practiced medicine in both times and fully realize the difference in the habits of people. Then we rarely went farther than 15 miles from home in a day. Then we had to work harder to make a living. We got tired physically rather than mentally and were in bed early.

Our diet was different. We ate what we raised on the farm. We never heard of hamburgers or cocktails. We knew nothing of roof gardens or roadhouses. We only knew of the little school house and churches. They were the only places visited. No one was wealthy in money but nearly all were honest. Their word was their bond. Their conscience was their guide. Their hearts were at rest.

C. E. Wilson, M.D.

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DR. HOWARD M. BURKETT, Associate Psychiatrist

MISS MARGUERITE HARMONSON,
Director of Nurses

O. G. DICKENSON, Hospital Administrator

MISS EURA GROSS, Director Occupational Therapy

OBITUARY

WILLIAM CLARK RUSSWURM, 88 years of age, died at his home in Helena June 9th. Born in Tate County, Mississippi, May 1, 1861, he graduated from Louisville Medical College in 1884 and practiced medicine in Mississippi until he moved to Phillips County, Arkansas, in 1885. He moved to Helena in 1895 and was married that same year to Miss Florence Boone, Coldwater, Mississippi, who survives him. Forced to discontinue surgical practice as the result of loss of his right arm in a fishing accident, he continued in the active practice of medicine until a few months ago. He was a honorary member of the Helena Rotary Club, a life member of the Helena Shrine Club, a member of the First Baptist church and an honorary member of the Arkansas Medical Society and had been elected to the "Fifty-Year Club" of the Society at the 1949 annual session.

BOOK REVIEW

A History of The Heart and The Circulation: By Frederick A. Willus, M.D., M.S. in Med., Senior Consultant in Cardiology, Mayo Clinic; Professor of Medicine,

Mayo Foundation for Medical Education and Research Graduate School, University of Minnesota; and Thomas J. Dry, M.A., M.B., CH. B., M.S. in Med., Consultant Section on Cardiology, Mayo Clinic; Associate Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. 456 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1948. Price \$8.00.

This history is divided into three sections, chronological presentation of knowledge to 1925, biographies and data according to subjects, and is a worthwhile addition to the field of medical history.

A. M. A. Interns' Manual: 209 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price \$2.25.

This small reference work contains the information needed by the intern in his hospital service; procedures in common emergencies, the doses and indications for over two hundred accepted drugs, standard laboratory tests, diets and reference tables. The present compilation is by joint effort of the Councils of Medical Education and Hospitals and of Pharmacy and Chemistry of the American Medical Association, and, while intended primarily for the intern, practitioners will find it useful and convenient.

Mayo Clinic Diet Manual: By The Committee on Dietetics of the Mayo Clinic. 329 pages. Philadelphia and London: W. B. Saunders Company, 1949. Price \$4.00.

A concise, compact and comprehensive manual giving both the foods essential to the diet and the omissions as well. This book will be useful to all who have occasion to deal with dietetics.

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Vol. XLVI

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No. 3

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FROM SECRETARY OF DEFENSE LOUIS JOHNSON—

AN URGENT APPEAL TO YOUNG DOCTORS!



Your personal help is needed to avert a serious threat to our national security!

By the end of July of this year we will have lost almost one-third of the physicians and dentists now serving with our Armed Forces. Without an increased inflow of such personnel, the shortage will assume even more dangerous proportions by December of this year.

These losses are due to normal expiration of terms of service. The professional men who are leaving the Armed Forces during this critical period are doing so because they have fulfilled their duty-obligations and have earned the right to return to civilian practice.

Without sufficient replacements for these losses, we cannot continue to provide adequate medical and dental care for the almost 1,700,000 service men and women who are the backbone of our nation's defense.

Normal procurement channels will not provide sufficient replacements!

To alleviate this critical, impending shortage of professional manpower in the three services, I am urging all physicians and dentists who were trained under wartime A. S. T. P. and V-12 programs under government auspices or who were deferred in order to complete their training at personal expense, and who saw no active service, to volunteer for a two-year tour of active duty, at once!

We have written personally to more than 10,000 of you in the past weeks urging such action. The response to this appeal has not been encouraging, and our Armed Forces move rapidly toward a professional manpower crisis!

Many responses have been negative, but worse—a great number of doctors have not replied. It is urgent that we hear from you immediately!

We feel certain that you recognize an obligation to your fellow men as well as to your profession in this matter. We are confident that you will fulfill that obligation in the spirit of public service that is a tradition with the physician and dentist.

There is much to be said for a tour of duty with any of the Armed Forces. You will work and train with leading men of your professions. You will have access to abundant clinical material; have the best medical and dental facilities in which to practice. You will expand your whole concept of life through travel and practice in foreign lands. In many ways, a tour of service will be invaluable to you in later professional life!

Volunteer now for active duty. You are urged to contact the Office of Secretary of Defense by collect wire immediately, signifying your acceptance and date of availability. Your services are badly needed. Will you offer them?

Louis Johnson

The JOURNAL

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FORT SMITH, ARKANSAS, AUGUST, 1949

No. 3

DIAGNOSIS AND TREATMENT OF THE CARDIAC ARRHYTHMIAS*

A. CARLTON ERNSTENE, M. D.

Cleveland.

Disturbances of the rhythm of the heart comprise one of the most common problems in clinical cardiology. They may occur as a complication of organic cardiac disease or in the entire absence of a structural abnormality of the heart. Certain arrhythmias are of no significance although they often cause disagreeable symptoms. Others result in an important reduction in the mechanical efficiency of the heart and may precipitate congestive myocardial failure or intensify pre-existing decompensation. Still others, among the more uncommon disorders, constitute a direct threat to life. Accurate diagnosis is essential not only for appropriate treatment but also for correct estimation of the clinical importance of the condition. Fortunately, most of the arrhythmias can be recognized by physical examination alone. Electrocardiographic corroboration of the diagnosis is always desirable, however, and a few of the disturbances can be identified only by instrumental means.

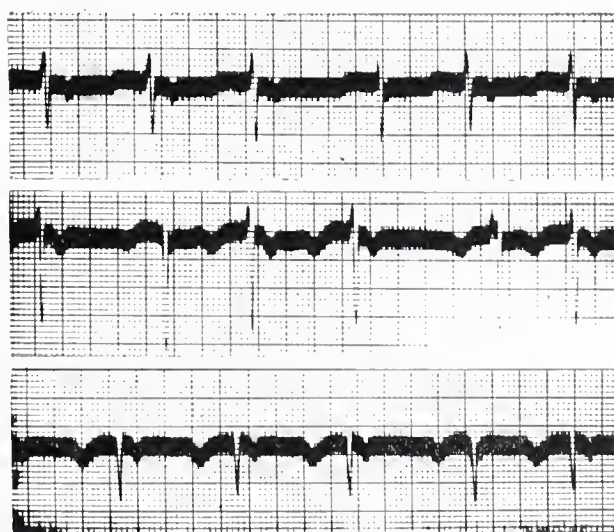
Premature Beats

Premature beats, the most common type of cardiac arrhythmia, may arise from the auricles, ventricles, auriculoventricular node or main stem of the bundle of His. They are of clinical significance only in exceptional instances although they not infrequently cause uncomfortable symptoms due either to the pause which follows the premature beat or to the unusual force of the next normal ventricular contraction. Patients frequently report a sensation that the heart has stopped momentarily or skipped a beat. Occasionally, in sensitive persons, there may be fleeting lightheadedness, a choking sensation in the throat, or transient pain in the precordial or substernal area.

Premature beats usually can be recognized without difficulty by auscultation of the heart.

The dominant cardiac rhythm is regular but is disturbed, at frequent or infrequent intervals, by a beat which comes before its expected time and is followed by a pause. If the beat is exceptionally premature it may fail to cause a perceptible pulsation in the radial artery. Auricular and nodal premature beats disturb the basic rhythm of the sinoauricular node and because of this the pause which follows them is not completely compensatory. The interval between the normal beat preceding the early beat and the first normal response after the premature systole is less than the length of two normal cycles. In ventricular premature beats, on the other hand, the rhythm of the normal pacemaker is not disturbed, and the compensatory pause is complete. Although one may at times estimate the completeness of the compensatory pause with fair accuracy by auscultation, the electrocardiogram is necessary for positive differentiation of the various types of premature beats.

Auricular premature beats are characterized electrocardiographically (fig. 1) by P waves which differ in form from the P waves of the patient's



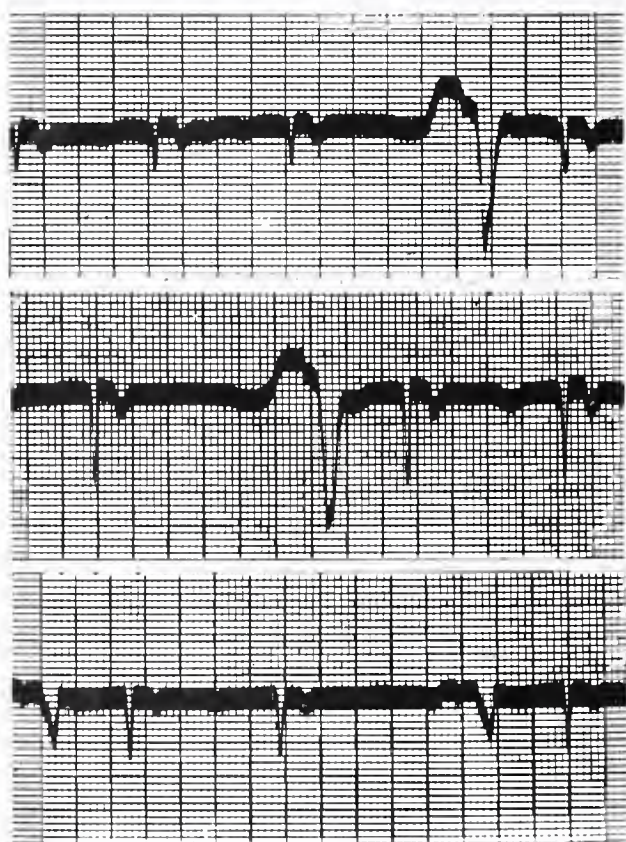
normal beats and are often inverted or diphasic. The P-R interval is usually longer than 0.10 seconds. The QRS complexes generally are similar to the normal QRS complexes, but if the

*From the Cleveland Clinic and the Frank E. Bunts Educational Institute.

Read before the Seventy-third Annual Session, Arkansas Medical Society, Little Rock, April 15, 1949.

premature beat occurs before the bundle branches or ventricular musculature have recovered from their refractory period, distinctly aberrant complexes may result.

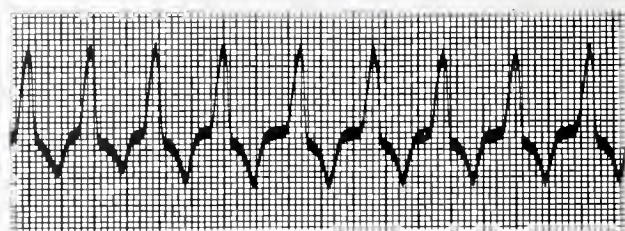
In nodal premature beats (fig. 2), the P waves also are of abnormal form but differ from the P waves of auricular premature beats in that they may occur after, during, or before the QRS complex. When they precede the QRS complex, the P-R interval is less than 0.12 seconds. The QRS complexes usually are similar to those of the normal beats.



Ventricular premature beats (fig. 3) cause abnormal, widened, slurred or notched QRS complexes which are not preceded by a P wave. Occasionally they may be interpolated between two normal cardiac contractions, in which event they constitute a true extra systole.

Since premature beats rarely are of significance, they seldom require treatment. Inquiry should be made concerning nervous tension and the excessive consumption of tobacco or coffee because control of these factors may diminish the arrhythmia or correct it entirely. In patients who are experiencing annoying symptoms or who have become concerned about the heart, reassurance is important and mild sedatives often are helpful. If symptoms persist in spite of these measures, quinidine sulfate, 0.2 Gm. (gr. 3) two

or three times a day may prove of value. Potassium chloride in doses of 1 or 2 Gm. three



or four times a day may also be effective but must not be administered to individuals who have renal disease. The fact that premature beats so frequently occur while a person is at rest and can be eliminated by physical activity should be pointed out, especially to apprehensive patients.

Although premature beats are observed in many normal individuals, they occur even more commonly in patients who have organic heart disease and are at times of clinical importance. The arrhythmia, for instance, may be an early manifestation of digitalis intoxication. Myocardial insufficiency is accompanied occasionally by the appearance of frequent premature beats arising from one or more foci in the ventricular myocardium. Digitalis therapy and sodium restriction may then reduce their number or abolish them entirely. In acute myocardial infarction, frequent premature beats are a potential precursor of ventricular paroxysmal tachycardia, and in their presence the administration of quinidine sulfate as a prophylactic measure against the development of this more serious arrhythmia is indicated. Numerous auricular premature beats are at times a forerunner of auricular fibrillation, especially in patients who have mitral stenosis. Quinidine sulfate and sodium restriction may be of value in preventing this type of progression.

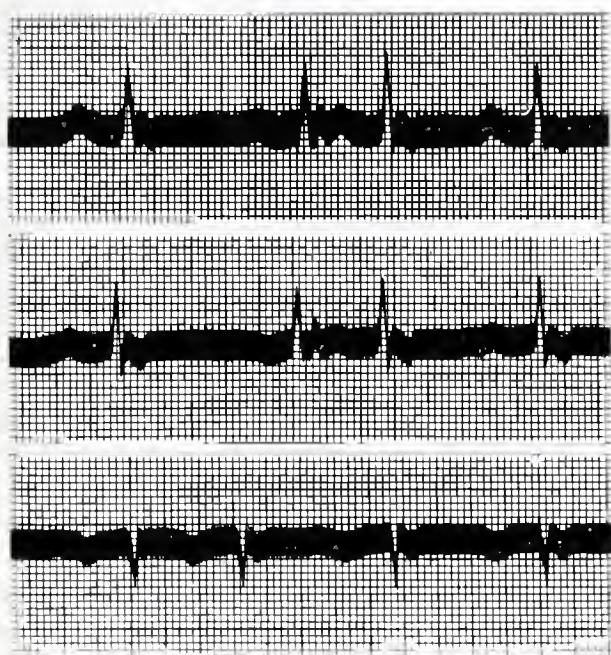
Auricular Paroxysmal Tachycardia

Auricular paroxysmal tachycardia consists fundamentally of a paroxysm of auricular premature beats and, next to premature beats, is the most common disturbance of cardiac rhythm. Characteristically, the attacks develop and end abruptly. They may last for a few beats only or for hours or days. The rhythm during the paroxysm is perfectly regular and the heart rate generally between 160 and 200 beats per minute. Although the condition occurs occasionally in persons who have organic heart disease, it is encountered most commonly in patients who present no abnormal cardiac findings.

In adults who have normal hearts, auricular

paroxysmal tachycardia causes no cardiac embarrassment even if the attacks persist for days. The patient, however, is often considerably disturbed by weakness, faintness, dizziness or palpitation. In infants and in individuals who have organic heart disease, a prolonged paroxysm may result in the development of congestive heart failure, and in persons with coronary artery disease, an attack may be accompanied by substernal pain which persists until the tachycardia is controlled.

The electrocardiogram in auricular paroxysmal tachycardia (fig. 4) shows a rapid, regular succession of QRS complexes which are typically of normal contour. The ventricular rate seldom varies more than two or three beats per minute. The P waves usually are diphasic or inverted,



and the P-R interval is prolonged. If no P waves are discernible, as is often the case, the condition cannot be distinguished from nodal paroxysmal tachycardia, and the term paroxysmal supraventricular tachycardia is then employed. Nodal paroxysmal tachycardia, however, is much less common than auricular paroxysmal tachycardia. The treatment of the two arrhythmias is the same.

There are a number of simple procedures which will abruptly terminate many attacks of auricular paroxysmal tachycardia. Among the most effective of these are holding a deep breath, pressure on the right or left carotid sinus, firm ocular pressure, and sudden flexion of the body at the hips. These measures either restore the heart rhythm to normal immediately or have no effect at all on the heart rate. If the tachycar-

dia persists and the patient is in distress, drug therapy becomes advisable. The treatment of choice in such a circumstance is rapid digitalization, preferably by the intravenous route. Weisberger and Feil¹ have reported excellent results from the intravenous administration of lanatoside C in doses of 0.8 mg. (4.0 cc.) followed by a second dose of the same size when the tachycardia was still present after 30 minutes to one hour. One must, of course, be certain that persons who are to receive digitalis by intravenous injection have not received the drug in any form during the preceding two weeks.

Youmans, Goodman and Gould² recently reported that Neosynephrine by rapid intravenous injection in doses of 0.5 mg. to 2.0 mg. will restore sinus rhythm in most cases of paroxysmal supraventricular tachycardia. The drug should not be administered to patients who have coronary artery disease or in whom hypertension is present during the tachycardia. Other preparations that often are effective are prostigmine methylsulfate, 0.5 to 1.0 mg., and mecholyl, 10 to 20 mg., repeated if necessary after 30 minutes. Both of these drugs are given by subcutaneous injection. Because of the frequency with which mecholyl causes symptoms of excessive parasympathetic stimulation, it is employed only rarely and only after a syringe containing atropine sulfate, 0.6 mg., has been prepared beforehand for intravenous use if necessary. Neither prostigmine nor mecholyl should be given to patients who have bronchial asthma, and the use of mecholyl is also contraindicated by the presence of coronary artery disease.

Ventricular Paroxysmal Tachycardia

Ventricular paroxysmal tachycardia is a relatively rare condition which usually is due to serious organic heart disease. It occurs most commonly as a complication of acute myocardial infarction, and in this situation it may be a forerunner of ventricular fibrillation. Occasionally, however, it is encountered in the entire absence of evidence of organic cardiac disease. As in the other types of paroxysmal tachycardia, the attacks usually are sudden in onset and termination, and the ventricular rate generally is in the range of 160 to 200 beats per minute. The electrocardiogram is necessary for certain identification of the arrhythmia, but Levine³ has pointed out that a reliable diagnosis can be made at times from the findings on physical examination alone. Although the rhythm in ventricular tachycardia at first impression appears to be regular, an occasional fleeting irregularity often can be detected by careful auscultation. This serves to distinguish the condition from auri-

cular paroxysmal tachycardia. Furthermore, if one listens carefully over the cardiac apex, an occasional accentuation of the first sound for a single beat frequently can be heard. In ventricular paroxysmal tachycardia, the auricles and ventricles beat independently, and the accentuation of the first sound at intervals is due to simultaneous auricular and ventricular systole. In auricular paroxysmal tachycardia, the auricles and ventricles contract in normal sequence, and the intensity of the first sound, therefore, does not vary. As an additional point in differential diagnosis, pressure on the carotid sinus does not terminate the attack of ventricular tachycardia as it does so often in auricular tachycardia.

Electrocardiographically, ventricular paroxysmal tachycardia is characterized by an uninterrupted series of ventricular premature beats occurring at regular or almost regular intervals but frequently differing slightly in form from beat to beat (fig. 5). P waves occur at their normal rate but it may be possible to recognize them only here and there. Unless P waves can be identified and the auricular rate estimated, a definite diagnosis of ventricular tachycardia cannot be made, for paroxysmal supraventricular tachycardia with aberrant QRS complexes and indiscernible P waves will produce a similar electrocardiogram.



Quinidine sulfate is the most valuable drug in the treatment of ventricular paroxysmal tachycardia. Although it can be given by intravenous injection, the oral route is used most commonly because of its greater safety. A number of different dosage schedules have been recom-

mended. One that has proved satisfactory consists of the administration of 0.2 Gm. as a trial dose, followed by 0.4 Gm. every two hours until the ventricular rate slows to 120 per minute. Gold⁴ advises that, when the rate has been reduced to this level, the electrocardiogram be repeated in order to determine whether or not auricular activity is present. If it is, the administration of the drug is continued until normal rhythm is restored. If no P waves can be seen, on the other hand, the dose of quinidine is reduced and the interval between doses lengthened in such a manner as to maintain a rate of approximately 120 beats per minute. Electrocardiograms are made at intervals of two to four hours, and the original schedule of dosage is not resumed until P waves reappear in the tracings. This is done in order to avoid a period of complete cardiac asystole when the arrhythmia is brought to an end.

When quinidine sulfate fails to terminate a paroxysm of ventricular tachycardia, the intravenous administration of 10 cc. of a 20 per cent solution of magnesium sulfate may reestablish sinus rhythm.

Auricular Fibrillation

Although auricular fibrillation may occur in young individuals as a purely functional disorder, it usually is associated with organic cardiac disease, especially rheumatic heart disease with mitral stenosis. It is a not infrequent complication of thyrotoxicosis and may also develop during the course of pneumonia and certain other febrile illnesses. In it, there is complete incoordination of the contraction of the muscle fibers of the auricles. Auricular systole is abolished, and the auriculoventricular node is showered by a rapid, irregular succession of impulses from the auricles. Ventricular contractions occur in response to a variable number of these, and a completely irregular ventricular rhythm results. Ventricular responses which follow the preceding systole by a very brief interval often fail to cause a pulsation in the peripheral arteries, and a pulse deficit results. It is the absolute irregularity of the heart, however, and the entire absence of an underlying basic rhythm that constitute the pathognomonic features of the disturbance.

Auricular fibrillation can be recognized without difficulty as long as the ventricular rate is elevated, but when the rate has been reduced by digitalis or is naturally slow, careful auscultation may be necessary to distinguish the condition from the arrhythmia of premature beats. A helpful point in differential diagnosis consists of the fact that with premature beats a long

pause is always preceded by an early beat, but in auricular fibrillation such pauses often occur without shortening of the interval between the two preceding beats.

In the electrocardiogram of auricular fibrillation (fig. 6), the rhythm of the ventricles is completely irregular and the P waves are replaced



by small, irregular, variable deflections, known as f waves, which usually have a rate of 400 to 450 per minute.

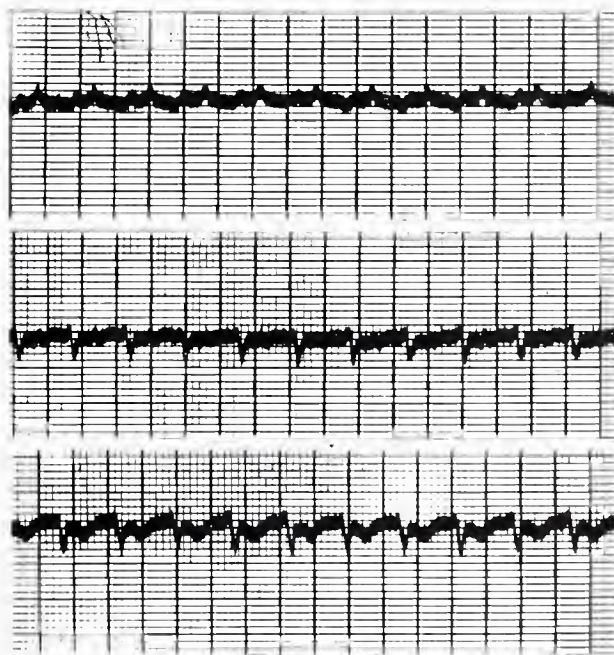
The presence of auricular fibrillation is always an indication for the administration of digitalis. When the ventricular rate is elevated, the drug is given in sufficient amounts to reduce the rate at rest to approximately 70 beats per minute. In the presence of hyperthyroidism, however, it is seldom possible to accomplish this degree of slowing before the appearance of symptoms of digitalis overdosage, and one should be content with ventricular rates between 90 and 100 per minute. Even when the ventricular rate is naturally slow in auricular fibrillation, digitalis is indicated in amounts sufficient to accomplish theoretical digitalization. This procedure usually does not cause further slowing of the ventricles but is recommended as a measure to prevent an undue rise in heart rate during physical activity or infections.

Digitalis does not possess the property of re-establishing normal rhythm in patients who have auricular fibrillation. Quinidine sulfate is employed for this purpose but the indications for its use are quite limited. It is of greatest value in cases in which the arrhythmia has developed as a complication of hyperthyroidism and persists after the thyrotoxicosis has been controlled

by thyroidectomy, propyl thiouracil or radioactive iodine. Quinidine can be employed also in cases of auricular fibrillation due to organic heart disease when the arrhythmia is known to be of recent origin and is not associated with mitral stenosis, congestive heart failure or more than slight cardiac enlargement. A history of an earlier embolic accident contraindicates its use. Administration of the drug should be preceded by complete digitalization, and maintenance amounts of digitalis should be given throughout the period of therapy. The patient must be kept under close observation and should remain in bed each day until two hours after the last dose of quinidine. The best results seem to be obtained when the drug is given with an interval of two hours between doses. On the first day, two doses of 0.2 Gm. are administered as a test for possible hypersensitivity. If no symptoms develop, five doses of 0.4 Gm. are given on each of the following days, but if auricular fibrillation is still present at the end of five days, the drug is discontinued.

Auricular Flutter

Auricular flutter is much less common than auricular fibrillation and rarely occurs in the absence of organic heart disease. It is due to essentially the same type of auricular disturbance



as auricular fibrillation but with the difference that regular auricular contractions of limited extent occur at a rate in the neighborhood of 300 or 350 per minute (fig. 7). Because a certain degree of auriculoventricular block is almost always present, the ventricular rate is slower when the block varies, an irregular rhythm re-

sults. If the auriculoventricular block is constant and of such a degree as to give a ventricular rate within the usual limits of normal, the presence of auricular flutter may be overlooked and first discovered only when an electrocardiogram is taken because of associated organic heart disease. Occasionally, in cases of this kind, however, careful inspection of the venous pulsations in the neck may reveal three or four or even more auricular pulsations to each ventricular wave.

When auricular flutter is present with a regular rhythm and a ventricular rate of 120 to 180 beats per minute it must be differentiated from sinus tachycardia and auricular paroxysmal tachycardia. In auricular flutter the ventricular rate remains constant within narrow limits and is not effected appreciably by exercise. This is in contrast to the variability of the rate in sinus tachycardia but does not aid in distinguishing the condition from auricular paroxysmal tachycardia. In auricular flutter pressure on the right or left carotid sinus may cause transient slowing of the heart or abrupt standstill of short duration followed by resumption of the original rate. The first of these responses may also be obtained in patients with sinus tachycardia but the second does not occur. In auricular paroxysmal tachycardia, pressure upon the carotid sinus either causes an abrupt reversion to normal sinus rhythm or has no effect at all.

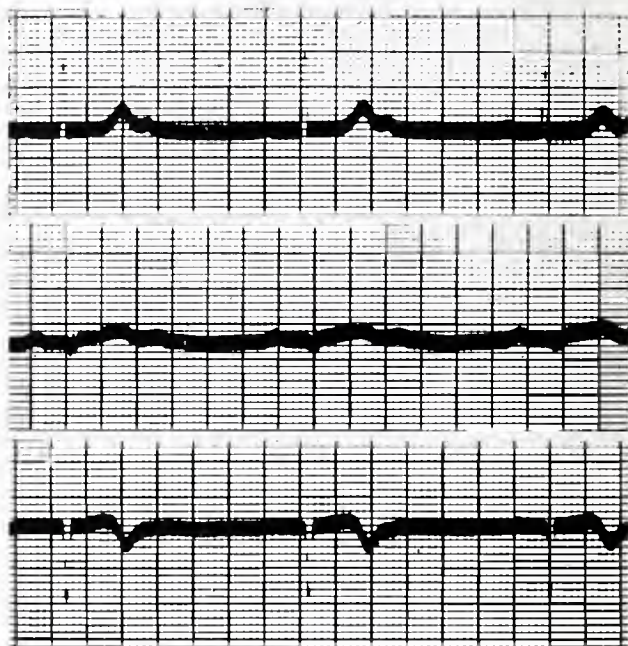
When the degree of auriculoventricular block in auricular flutter is variable, the ventricular rhythm is irregular and may suggest auricular fibrillation. Careful auscultation usually enables one to detect an underlying dominant rhythm, however, and this distinguishes the condition from auricular fibrillation. Furthermore, pressure upon the carotid sinus in auricular fibrillation has neither of the effects upon the rate of the ventricles which occur in auricular flutter.

Although the administration of quinidine sulfate may convert auricular flutter to sinus rhythm, the treatment of choice consists of rapid digitalization. In successful cases, digitalis converts auricular flutter to auricular fibrillation, and discontinuance of the drug may then be followed by spontaneous resumption of normal rhythm. If the flutter persists, digitalis is continued in the amount required to maintain sufficient auriculoventricular block to result in a ventricular rate of 100 beats per minute or less.

Auriculoventricular Block

Auriculoventricular block may be of any degree from simple lengthening of auriculoventricular conduction time to complete dissociation of the auricular and ventricular waves. When the degree of block

is constant, the ventricular rhythm is regular, but the auricles and ventricles. Prolonged conduction between the auricles and ventricles, termed first degree auriculoventricular block, can be recognized with precision only by means of the electrocardiogram. The higher grades of block, namely second degree block with occasional or regularly recurring dropped beats and complete auriculoventricular dissociation, often can be diagnosed from the findings on auscultation of the heart. When there are occasional dropped beats, one must be sure that an early and faint premature beat is not being overlooked. In 2:1 block (fig. 8), the ventricular rate is slow, usually in the



neighborhood of 40 per minute, and an extra heart sound may be audible shortly after the second sound. This results from those auricular contractions which are not followed by a ventricular response. In complete auriculoventricular block (fig. 9), the ventricular rate is usually less than 40 per minute. The extra sounds due to the auricular beats can be detected at times, and there usually is an occasional accentuation of the first sound at the apex due to the chance occurrence of practically simultaneous contraction of the dissociated auricles and ventricles.

Complete auriculoventricular block and second degree block with a slow ventricular rate must be distinguished from sinus bradycardia. This may not be possible by physical examination unless the auscultatory signs mentioned are present or unless one can detect extra auricular waves on inspection of the jugular pulse. Diagnostic help may be obtained, however, from the fact that in complete block exercise causes little

or no change in the ventricular rate, but in sinus



bradycardia a distinct increase in rate usually results.

In patients who have myocardial insufficiency, the presence of auriculoventricular block does not contraindicate the administration of digitalis. When the block is of first or second degree, digitalization should be accomplished gradually, and the effect of the drug should be observed by daily electrocardiograms. If the degree of block increases, it may be advisable to be satisfied with less than complete digitalization.

The higher grades of auriculoventricular block, and particularly complete auriculoventricular dissociation, may be complicated by the Adams-Stokes syndrome due to sudden slowing of the ventricular rate, temporary standstill of the ventricles, or the occurrence of ventricular paroxysmal tachycardia. The attacks are characterized by faintness, dizziness, syncope, or convulsions, depending on the extent to which cerebral circulation is diminished. Adams-Stokes seizures are rare, but individuals in whom they occur are liable to have repeated attacks. The actual seizures usually are of such short duration that they do not require treatment, but in rare instances ventricular standstill is of sufficient duration to threaten life, and the intracardiac injection of epinephrine hydrochloride, 0.5 to 1.0 cc. of 1:1000 solution, is indicated. The most effective drugs for preventing recurrent attacks due to sudden ventricular slowing or ventricular asystole are epinephrine hydrochloride, 0.3 to 1.0 cc. of the 1:1000 solution, subcutaneously or intramuscularly every two to four hours, ephedrine sulfate by mouth in doses of 24 to 30 mg. every four to six hours, and paredrine by mouth in doses of 40 to 60 mg. three times a day.

SUMMARY

The clinical features and treatment of the

various types of cardiac arrhythmia have been discussed. The two most valuable drugs in treatment are digitalis and quinidine sulfate and the indications for their administration have been reviewed.

The clinical characteristics of the disturbances of cardiac rhythm have been so well established that it is impossible to recognize most of them without mechanical aid. Premature beats, auricular paroxysmal tachycardia, ventricular paroxysmal tachycardia, auricular fibrillation, auricular flutter, and high grade or complete auriculoventricular block usually can be detected by careful physical examination alone. Electrocardiographic corroboration of the diagnosis is always desirable, but the electrocardiogram is of much greater value today in the detection of heart muscle damage and disturbances of intraventricular conduction than in the differentiation of the cardiac arrhythmias.

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LEGENDS

Fig. 1. Auricular premature beats. The P waves of the premature beats differ in form from that of the normal beats, but the QRS complexes show only minor alterations. The compensatory pause is incomplete.

Fig. 2. Nodal premature beats. With the exception of the first premature beat in lead II, the P waves of the premature beats fuse with the beginning of the QRS complexes.

Fig. 3. Ventricular premature beats. The QRS complexes of the premature beats are wide, slurred and distinctly abnormal, and they are not preceded by a P wave. The compensatory pause is complete.

Fig. 4. Auricular paroxysmal tachycardia. There is a rapid succession of QRS complexes which are of normal contour. The rate is 188 per minute. The P waves are diphasic in leads 2 and 3, and the P-R interval is at least 0.16 seconds.

Fig. 5. Ventricular paroxysmal tachycardia. The QRS complexes are wide and slurred, and the rhythm is not quite regular. The ventricular rate is 140 per minute. Only a rare P wave can be identified.

Fig. 6. Auricular fibrillation. The P waves are absent and have been replaced by small, irregular f waves. The ventricular rhythm is completely irregular.

Fig. 7. Auricular flutter with 2:1 block. The ventricles respond to every second flutter wave. The flutter waves are triangular in shape, perfectly regular, and not

separated by an isoelectric interval.

Fig. 8. 2:1 auriculoventricular block. Every second auricular impulse is blocked at the A-V node, and the corresponding ventricular beat fails to occur.

Fig. 9. Complete auriculoventricular block. All auricular impulses are blocked at the A-V node, and the activity of the ventricles is governed by an ectopic focus in the bundle of His.

YOUR BLUE SHIELD

... Lest We Lose by Default

What is the significance of the word "voluntary?" We have used it so often that it is in danger of becoming a stereotyped label instead of a living word filled with energy and promise. The dictionary defines "voluntary" as "acting of one's free will, choice or accord; spontaneous; free; not compelled by another; unrestrained by any external influence, force, or interference."

The merits of voluntary action in providing health care have been established over the years in the development of voluntary hospital, medical and surgical care plans and in the progress of our medical sciences. More than 1,500 physicians in this State are meeting the needs of the public and preserving the traditions and character of their profession through participation in the Florida Blue Shield Plan, the "doctors' plan" that helps protect people of moderate income against unpredictable medical costs. The development of a voluntary method for bringing medical care within the financial reach of the public is evidence that the doctors are not "sitting back to see what happens."

Voluntary Blue Shield Plans throughout the country are being made successful by the active endorsement and participation of progressive doctors in the areas served. Their success and strength will increase with the growing cooperation of the medical profession.

What are the demonstrated merits of the voluntary system? Why does it deserve the support of a medical profession eager to preserve the traditions of private initiative and free enterprise? What is its appeal to the public?

The greatest merit of the voluntary medical plans is the fact that they provide a practicable solution to the problem without altering established patient-physician relationships. The voluntary system does not attempt to redesign the fabric of American medicine. Its objective is to make existing facilities available to a greater number of people at a cost all can pay.

Members have free choice of doctors, and the payments made for services rendered are based upon a realistic schedule. The Florida Medical Association has approved the agreement be-

tween Blue Shield and the Participating Physicians who have thereby demonstrated their willingness to offer the low income patient protection for which he would otherwise not be able to make payment. Because the plan functions on a community level, there is a maximum of direct contact with the doctor and a minimum of red tape.

From the patient's point of view, voluntary prepayment plans offer an opportunity for protection against health costs that does not involve loss of self respect or independence. The very fact that the patient has gained this protection by his own choice and is paying for it without compulsion adds to his self respect and feeling of adequacy.

The voluntary method, by its definition, is the logical method to receive the encouragement of those who wish to practice "unrestrained by any external influence, force or interference." That encouragement may be given by becoming a Participating Physician and by bringing the benefits of the plan to the attention of patients.

Any licensed physician may become a participant in the Florida Blue Shield Plan. All physicians should become familiar with its objectives and provisions so that they may discuss it with their patients and friends.

We all know and value the merits of the voluntary system. Both doctors and patients will enjoy its growing advantages in the future unless, by taking it for granted, we lose it by default.

—Journal Florida Medical Association,
May, 1949.

FOR SALE: Must sell as soon as possible electro-therapy equipment left in the J. R. Crigler estate, Alma, Arkansas. Short wave diathermy (2); polysine, electro-surgical units (Bovine and Cameron); Burdick vasculator, and others.

Contact Dr. R. E. Crigler, Holt-Krock Clinic, Fort Smith, Arkansas.



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EDITORIAL

A ONE-SENTENCE EDITORIAL

"He has erected a multitude of new offices, and sent hither swarms of officers to harass our people, and eat out their substance"—The Declaration of Independence.

THE ATLANTIC CITY SESSION OF THE AMERICAN MEDICAL ASSOCIATION

A total of 13,221 physicians registered at the Atlantic City session of the American Medical Association June 6-10, 1949, the second highest attendance in the Association's history. E. L. Henderson, Louisville, became president-elect; James F. Norton, Atlantic City, vice-president; George F. Lull, Chicago, secretary; J. J. Moore, Chicago, treasurer; F. F. Borzell, Philadelphia, speaker, House of Delegates; James R. Reuling, Bayside, N. Y., vice-speaker; Louis H. Bauer, Hempstead, N. Y., and F. J. L. Blasingame, Wharton, Texas, trustees.

Among the many resolutions which received favorable action in the House of Delegates were the two introduced by the Arkansas Medical

Society: (1) calling for disapproval of proposed school health legislation by the Federal government and (2) recommending that the American Medical Association institute a system of inspection and grant approval to hospitals meeting its standards. A National Health Conference to meet during the year was approved and an effort to discontinue the general practitioner's award was defeated. Other resolutions approved requested an amendment to the Constitution which would keep the Federal government out of business in competition with its citizens, (2) insistence that physicians and other self-employed persons be excluded from any expanded social security legislation, (3) to amend the United States compensation laws so as to provide for free choice of physicians, (4) the creation of a new scientific section, the Section of Physical Medicine and Rehabilitation. Approval was had for a resolution which favored complete separation of Associated Medical Care Plans from the American Medical Association.

The Distinguished Service Medal was awarded to Dr. Seale Harris of Birmingham. The Board of Trustees announced a change in the policies which affect the Editor of The Journal, Dr. Morris G. Fishbein.

Color television was the interesting feature of the scientific exhibit and television interpretation of X-ray films was initially presented.

Senator John L. McClellan distinguished himself and Arkansas by his address at the Grass Roots Conference of County Medical Society Officers, taking the definite stand that Congress cannot legislate good health for the American people and that good health will not be obtained by compulsory measures. He estimated the cost of proposed compulsory health insurance measures at from 12 to 20 billion dollars and doubted very seriously that our present economy could sustain such a deduction.

Arkansans met in annual breakfast session on June 9th with 27 present. Visiting physicians from England discussed the plight of British medicine under the National Health Act, and stated that they were, at no time, seriously consulted concerning provisions of the legislation.

CHANGE OF ADDRESS

Due to a new postal regulation copies of The Journal addressed to the last address of our subscribers will not be delivered to the new address even though that address be in the same city. For this reason a number of July Journals have been returned to the office of The Journal. This involves an unnecessary expense in that these

DOCTOR *at Stovers*

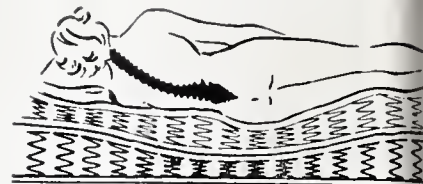
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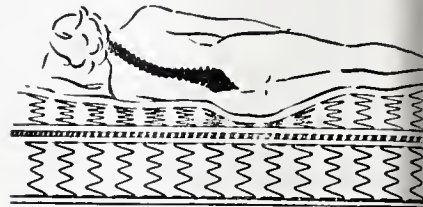
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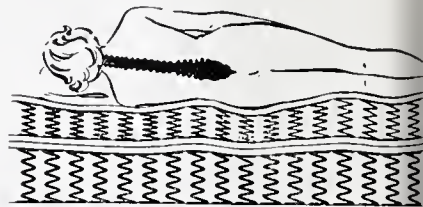
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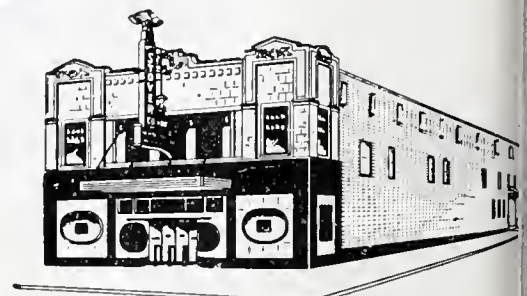
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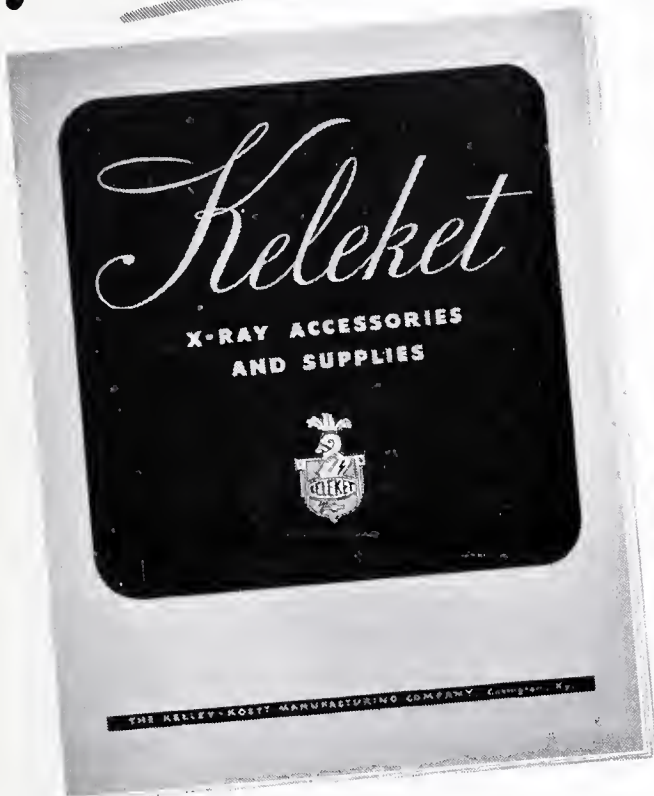


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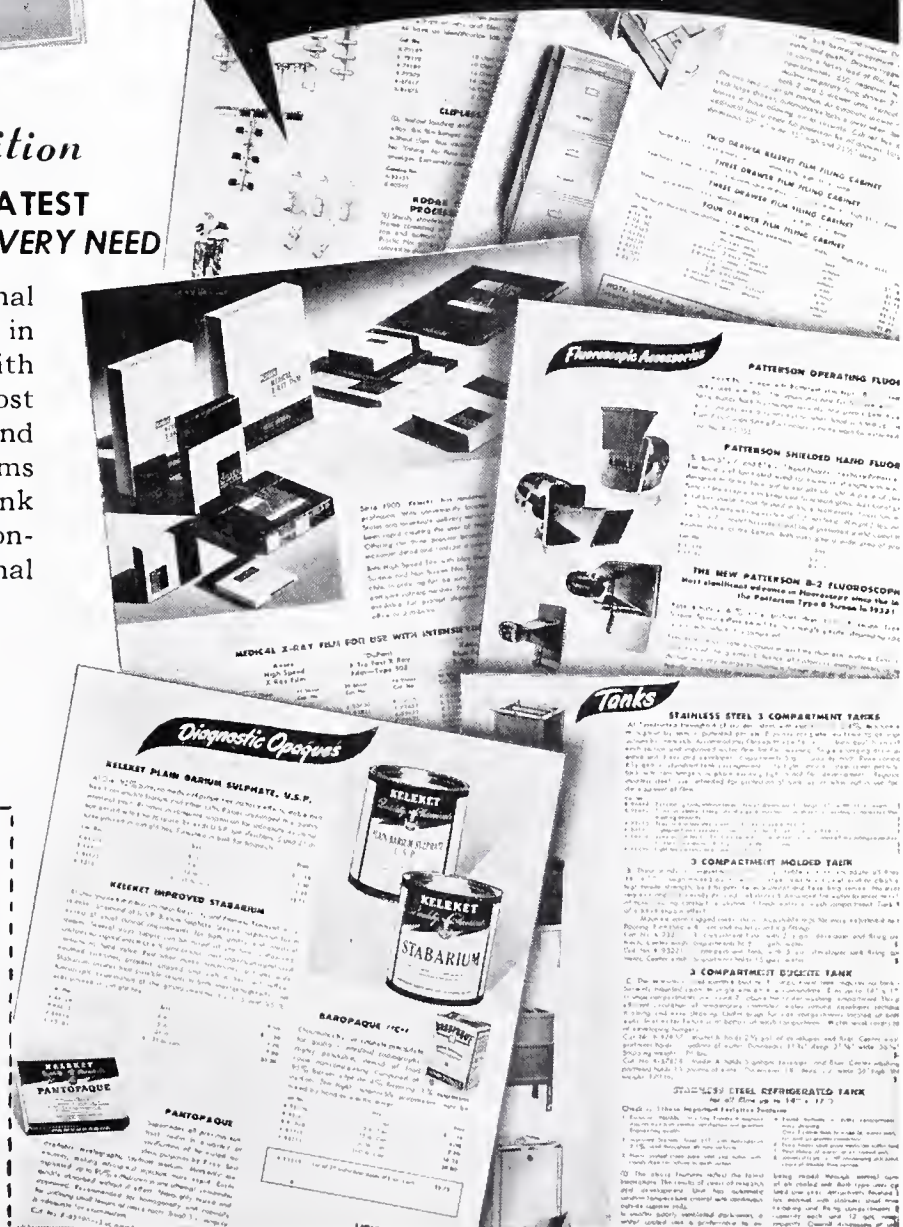
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RANDOM THOUGHTS OF THE SECRETARY

July 4th. In 1776 we declared our independence of a government across the seas; in 1949 we seek to establish our dependence upon a government in Washington.

July 5th. Attending the Lions Club today which is visited by the Johnson County Peach Festival delegation and fortunate enough to be seated with the Maids. Surprised to receive a build-up from McAnear of the Clarksville Chamber of Commerce who welcomes us saying: "A friend of Siegel's is a friend of Johnson County!"

July 6th. The vagaries of rumors inflict their punishment upon us this day and we occupy a good portion of our afternoon in the effort to ascertain new policies which may apply to a Veterans Administration hospital.

July 7th. Meeting this day with the Arkansas Tuberculosis Association board and with sundry committee members, conducting a personal crusade against sport shirts and lack of ties at the board meeting, convincing Ab Jenkins, Upjohn's affable and dignified representative, but momentarily of the tenability of our crusade.

July 10th. With the support of Trustee Blasingame, Louisiana's Graves and Lawson, Tennessee's Hamilton and Webb, Mississippi's Dye and Oklahoma's Graham, the Arkansas group discusses with profit the 20-point program for approval of lay-sponsored health organizations, school health legislation and extension of social security, all hoping that plans initiated here may carry over the country. Concluding the day's session with a council meeting and departing homeward, Graham telling Richardson all the way of activities and progress within the Sooner State and well he may boast. Richardson then becomes our congenial porch visitor until arrival of his transportation, a pleasure not often our lot.

July 12th. Milton John sends us a clipping from the society columns of the Arkansas Democrat which tells of Paul Mahoney completing a course in rhino-plastic surgery.

July 14th. With the younger group at the Cooper Clinic picnic tonight but observing that us youngsters do not pull off shirts nor engage in the boyish pastimes which have typified some of these gatherings in the past: tonight exuberance on our part is confined to flash photography.

July 15th. Calling on Breshnahan, the new Veterans Administration hospital manager at Fayetteville, finding him affable and intent at his duties and conversation ranges from fly-fishing in the Ozarks to veterans medical care and medical education.

HOMER DICKENS, age 56 years, of DeWitt, died of a heart attack June 6th. Born in Merit, Texas, June 8, 1892, he attended Howard Payne College, Grayson College and Baylor University and graduated from the University of Tennessee School of Medicine in 1914 at the age of 21 years. Shortly after graduation he married Miss Onie Cox and they located at St. Charles, Arkansas. In 1924 he moved to DeWitt. He was a 32nd degree Mason, a past grand master of the St. Charles Lodge, F. & A. M., a past-president of the Arkansas County Medical Society and of the DeWitt Lions Club. He was a charter member of Alpha Kappa Kappa at the University of Tennessee School of Medicine chapter. Surviving are his wife and two sons.

LESTER LEE SCOTT, 60 years of age, died at his home in Siloam Springs August 11, 1948, after an illness of nearly seven years which had forced his retirement from active practice. Born at Magazine, Arkansas, September 23, 1882, he attended schools in Booneville and Fort Smith, and graduated in medicine from the University of Louisville Medical School in 1907. He first located for practice at Hackett but moved to Siloam Springs in 1920. Surviving relatives are his wife and a daughter.

SURPRISINGLY LOW PROTEIN INTAKE OF PREGNANT WOMEN

Six separate investigations* on the protein intake of pregnant women are in striking agreement concerning the low percentage of patients obtaining an amount which is regarded as an adequate daily protein intake. As a criterion, these investigators used protein intakes of 80 or 85 Gm. daily. The percentage of patients obtaining at least these amounts was low, ranging from 7 to 37 per cent. The use of Mead's concentrated protein foods, Protenum and Casec, greatly simplifies the problem of encouraging an optimum intake of protein during pregnancy. Both of these preparations, consisting of protein of high biologic value, are palatable and can be incorporated in a number of attractive recipes.

For literature on Protenum and Casec, write Mead Johnson & Company, Evansville 21, Indiana.

* Bibliography on request.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

HERE has been little research directed at testing the efficiency of mechanical barriers to the air-borne passage of tubercle bacilli. Yet the importance of this type of study scarcely needs to be pointed out to the physician and the nurse whose duties bring them in close contact with cases of active tuberculosis.

THE EFFICIENCY OF GAUZE MASKS*

Although there is no certain knowledge as to the size of the infectious particles concerned in the origin of human inhalation tuberculosis, there is considerable evidence to suggest that these are much smaller than the limits of ordinary visibility. Primary pulmonary tuberculosis in man takes root not in the upper respiratory passages but deep in the lung parenchyma, usually beneath the pleura. The effective pathogenic units must be assumed, therefore, to be smaller than the lumina of the terminal bronchioles. That the tubercle-bacilli-containing-particles responsible for naturally acquired air-borne pulmonary tuberculosis in rabbits are of microscopic dimensions is indicated by the fact that ultraviolet irradiation of the air of a room contaminated by tubercle bacilli protected rabbits from an air-borne contagion that caused progressive tuberculosis in 73 per cent of animals of the same genetic resistance similarly exposed in an un-irradiated room. The ventilation of the irradiated room was such that some of the droplet nuclei of tubercle bacilli floating in the air were exposed to irradiation for only one second before inhalation by the exposed rabbits.

Therefore, it was not certain whether gauze masks and pores of relatively large magnitude, such as may be worn by individuals exposed to air-borne contagion of human tuberculosis, would filter out the dangerous invisible droplet nuclei of tubercle bacilli. There is evidence that six layer gauze masks, especially after repeated washing, will remove bacteria floating in the air without interfering with respiration.

Miss Esta H. McNett, of the Veterans Administration, designed a six-layered gauze mask to be worn by nurses engaged in the care of tuberculous patients. The efficiency of these masks was studied in an apparatus for quantitative air-borne infection modelled after the one described by

Wells. The protective action of the gauze masks developed by Miss McNett was tested against the quantitative inhalation of droplet nuclei of tubercle bacilli which regularly induce pulmonary tuberculosis in rabbits.

The essential feature of the instrument was a nebulizer which generated droplet nuclei of tubercle bacilli. Most of these nuclei contained isolated bacilli; only occasionally were minute clumps, not larger in diameter than a red blood cell, liberated into the air. This infected air was drawn into an exposure chamber, into which the heads of the rabbits to be exposed protruded through a close-fitting collar. The infected air circulated past the noses of the rabbits and was removed through an exhaust pipe.

Three and six-layer gauze masks, 40 by 44 threads to the square inch, were sewn to fit the contour of the rabbit's head, neck and ears. The gauze in front of the rabbit's nose and mouth had no seams.

Rabbits without masks and rabbits wearing masks were exposed simultaneously to the inhalation of air containing droplet nuclei of virulent bovine tubercle bacilli of the Ravenel strain.

It was found that, if all the air respired by rabbits exposed to the inhalation of droplet nuclei of virulent bovine tubercle bacilli passes through three or six-layer gauze masks, there is a 90 to 95 per cent reduction in the incidence of primary pulmonary tuberculous foci which develop within five weeks. It would follow that, if the respired air contains but a few bacilli, the masked animal will usually be protected from an otherwise fatal infection. Twelve of 20 masked animals were completely protected against air-borne contagion of such intensity that from 29 to 1,027 tubercle bacilli units were deposited in the lungs of simultaneously exposed unmasked rabbits.

Measurements of the thread diameters and

interthread spaces of these masks by H. Shapiro showed that the superimposition of three to six layers of this material would occlude practically all of the spaces and in this way explain the results of the experiments.

One must be extremely guarded in applying these data to the protection of human beings. With the rabbits all of the respired air passed through the masks. To be equally effective for human beings exposed to air-borne infection of tuberculosis, masks must be worn in an equally effective manner. The masks protected rabbits from air populated with droplet nuclei of tubercle bacilli to a degree that would rarely, if ever, be found in the air respired by human beings. Human primary tuberculosis usually originates as a single pulmonary focus, whereas the unmasked rabbits in these experiments developed an average of 51 primary tubercles. Nevertheless, it seems reasonable to advise persons wearing masks to refrain from deep inspiration which may diminish the filtering efficiency of the masks.

Conversely, masks worn by coughing patients can hardly be expected to retain the invisible droplet nuclei containing tubercle bacilli propelled through them during fits of coughing.

Summary—Under the conditions of these experiments, from 90 to 95 per cent of pathogenic droplet nuclei of virulent bovine tubercle bacilli in the respired air can be removed by gauze masks properly worn by rabbits during quiet breathing of heavily infected air.

THE FACE MASK IN TUBERCULOSIS†

The major obstacle to the rapid expansion of better care for tuberculosis patients and to the education of student nurses in tuberculosis nursing seems to be the recognized danger of contagion. The only known methods of protection for nurses against tuberculosis are: BCG (Bacillus Calmette Guerin) vaccine, available only to tuberculin-negative nurses, and communicable disease technic, based upon the use of mechanical agents—cap, mask, gown, and hand-washing. None of these agents except the mask protects nurses and auxiliary workers from infection by inhalation which modern medical opinion regards as one of the most important mechanisms in the transmission of tuberculosis.

* The Efficiency of Gauze Masks, Max B. Lurie, M. D., and Samuel Abramson, V.M.D., American Review of Tuberculosis, January, 1949.

† The Face Mask in Tuberculosis, Esta H. McNett, R. N., American Journal of Nursing, January, 1949.

PROCEEDINGS OF SOCIETIES

Craighead-Poinsett County Medical Society met in Jonesboro July 7th with the following scientific program: "Three Surgical Cases," A. B. Stegall, Memphis.

Greene-Clay County Medical Society met in Paragould on June 22nd for the following scientific program: "Circulatory Injuries in Bone Fractures," Moore Moore, Jr., Memphis, and "Recent Advancements in the Treatment of Urinary Tract Infections," Alfred D. Mason, Jr., Memphis.

W. McD. Lamb, Secretary.

Announcement is made that the Tri-State Medical Society (Arkansas, Louisiana and Texas) will be re-organized at a meeting to be held in Texarkana October 5th, 1949. All members of the Arkansas Medical Society are invited. The program will appear in a later issue of The Journal.

"The Doctor's Heart" by L. H. McDaniel, Tyronza, appears in the June issue of the Southern Medical Journal.

PERSONALS AND NEWS ITEMS

D. W. Goldstein, L. A. Whittaker and W. R. Brooksher addressed the Fort Smith Rotary Club June 22nd on the 1949 annual session of the American Medical Association.

Geo. B. Fletcher, Hot Springs National Park, attended the recent sessions of the American Academy of Neurology at French Lick, Indiana.

Max Baldrige, who was located at Conway prior to service with the United States Navy during World War II, has completed a three-year residency in ophthalmology at Washington University and Barnes Hospital, St. Louis, and is now associated with the Southern Clinic at Texarkana.

Dr. and Mrs. Fred H. Krock, Fort Smith, spent a recent vacation in California.

Carl A. Rosenbaum has moved his office to 909 Main Street, Little Rock.

Dr. and Mrs. W. F. Adams, Fort Smith, spent a recent vacation in south Texas.

Floyd Webb announces the association with him in practice of Jack Webb who has completed a residence in ophthalmology at Tulane University and who took additional work at

Knoxville General Hospital and at Montipore Hospital, Pittsburgh. He served with the Army Medical Corps during World War II.

W. A. Reilly, Little Rock, addressed the Southern Pediatric Seminar, Saluda, North Carolina, July 25 and 26th on "Pyogenic Meningitides" and "Common Endocrine Problems."

Ellis Gardner, Russellville, has been elected president of the Arkansas Tech Alumni Association.

Hoyt R. Allen, Little Rock, has been elected President-Elect of the American Proctologic Society.

BORN—On June 15th, Jere Jane, to Dr. and Mrs. Jerome S. Levy, Little Rock.

John M. Hundley, who has been in an orthopedic residency at St. Louis has opened his office for practice at 334 Donaghey Building, Little Rock.

T. H. Jones, Waldo, is taking special work in Chicago and will then locate with his brother, W. E. Jones, formerly of Morrilton, at Seminole, Oklahoma, where they have erected a 11-room clinic building.

Friedman Sisco has been elected surgeon of the Springdale post, American Legion.

Art B. Martin has been elected president of the Fort Smith chapter, Arkansas Tech Alumni Association.

The following have been elected surgeons of their respective American Legion posts: N. C. Bogart, Forrest City; Virgle Lyons, North Little Rock, and John McCullough Smith, Little Rock.

Charles Wallis, Little Rock, announces the association with him of Robert Lee Henry in the practice of pediatrics.

WOMAN'S AUXILIARY NEWS

The Auxiliary to the Pope-Yell County Medical Society was reorganized Thursday June 23rd, at Russellville. Mrs. Louis K. Hundley, president of the Auxiliary to the Arkansas Medical Society, spoke to the physicians and their wives at a dinner at St. Mary's hospital. Dr. Hundley, chairman of the Advisory Council of the Auxiliary, also was introduced.

During the scientific session the ladies met at the home of Mrs. Roy Millard to discuss plans

for organization. The following officers were elected: Mrs. Millard, president; Mrs. Ellis Gardner, vice-president; and Mrs. Max J. Mobley, secretary-treasurer.

Mrs. Millard appointed the following committee chairmen:

Constitution and By-Laws, Mrs. Ellis Gardner.

Public Relations, Mrs. L. Gardner.

Doctor's Day, Mrs. W. O. Young.

Program, Mrs. Kent Grace.

Biography, Mrs. J. M. Stanford.

Education and Public Health, Mrs. Brooks Teeter.

Membership, Mrs. Max Mobley.

Charter members of the group include: Mrs. J. K. Grace, Belleville; Mrs. J. M. Stanford, Russellville; Mrs. Roger Blackford, Russellville; Mrs. Max J. Mobley, Russellville; Mrs. Brooks R. Teeter, Russellville; Mrs. Robert L. Lichtenberg, Russellville; Mrs. A. Watson Miller, Russellville; Mrs. L. Gardner, Russellville; Mrs. Roy I. Millard, Russellville; Mrs. W. O. Young, Russellville; and Mrs. Ellis Gardner, Russellville.

The group passed a resolution against government control of medicine, voting to send copies to the President, the two senators from Arkansas, and Congressman Brooks Hays.

Mrs. Mason G. Lawson, past-president of the Woman's Auxiliary of the Arkansas Medical Society was recently elected 4th vice-president of the Woman's Auxiliary to the American Medical Association.

The semi-annual meeting of the First Councilor District of the Medical Society held in Tyronza, Arkansas, in May had as one of their guests our state president of the Woman's Auxiliary, Mrs. Louis K. Hundley. She urged all doctors wives to read and study literature pertaining to socialized medicine.

The Woman's Auxiliary to the Arkansas Medical Society of Washington County had their last meeting March 16, followed by a tea at the Washington Hotel.

A large crowd of invited guests were present. The subject of socialized medicine was discussed by Mrs. Mason G. Lawson, president; Mrs. Louis K. Hundley, president-elect, and Mrs. Charles Henry, first vice-president.

Senate Bill No. 5 was one topic claiming particular attention. As a result of the inspiration and enthusiasm of our speakers the Washington County Medical Auxiliary has met every week for three months in order to do our part in acquainting ourselves with all phases of Senate

Bill No. 5, and all latest legislation dealing with socialized medicine.

The Woman's Auxiliary to the Hot Springs County Medical Society met on June 14 with the doctors for a dinner meeting at the Barlow Hotel. Dr. and Mrs. C. R. Ellis were hosts for the evening. Dr. Joe Shuffield was guest speaker. Other guests were Dr. Elvin Shuffield, Little Rock, and Dr. and Mrs. C. W. Parkerson, Hot Springs.

Following the dinner the Auxiliary held a short business meeting with Mrs. C. F. Peters, Jr., President, presiding. The minutes of the previous meeting were read and approved. A short discussion was held on ways and means of purchasing linens for the new hospital, which is nearing completion.

There being no further business the meeting was adjourned.

Mrs. C. R. Ellis,
Publicity Chairman.

IN MEMORY OF MRS. HOMER A. STROUD OF JONESBORO

At last a rest that's well deserved has come to one who toiled.

At home, abroad or Sunday School she was always near the Lord.

She never grew tired of doing good, nor failed when duty called.

She lived a life that should be an inspiration to any one who cares to emulate it.

There is no need to grieve for one whose life has been so well spent. There is another bright side too, this good woman will be spared the care and sorrows of this world. Even though we grieve we can rejoice in the fact that her salvation is secure forever in a place where there is no more pain, no more fear, no more suffering and no more death.

We ask the Lord to be with this family and loved ones. May they turn to Him in this hour of sorrow and look to One Who doeth all things well.

With sincere sympathy,
Craighead-Poinsett Medical Society.

BOOK REVIEW

Psychiatry in General Practice: By Melvin W. Thorner, M. D., D. Sc., Assistant Professor of Neurology, The Graduate School of Medicine, University of Pennsylvania. 659 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price \$8.00.

This is a most interesting volume and brings the general practitioner in readable form, shorn of verbosity usually attendant upon the subject, and appreciation of the

part that psychiatry plays in every-day practice. Typical case histories serve well to illustrate the applications of the specialty.

Oral and Dental Diagnosis—With Suggestions for Treatment: By Kurt H. Thoma, D. M. D., F. D. S. R. C. S. Eng., Professor of Oral Surgery, Emeritus, and Brackett Professor of Oral Pathology, Harvard University. With Contributions by Henry Goldman, D. M. D., Head of the Dental Department, Beth Israel Hospital, Boston; Fred Trevor, D. M. D., Formerly Instructor in Oral Pathology, Harvard Dental School. New, 3rd edition. 563 pages with 776 illustrations, 60 in color. Philadelphia and London: W. B. Saunders Company, 1949. Price \$9.50.

Oral and Dental Diagnosis by Dr. Kurt H. Thoma is the most complete text on oral diagnosis I have encountered. Diseases and malformations, both simple and most complex, are treated in Thoma's usual complete and thorough manner. In addition to its material on diagnosis, it has suggested treatments, both local and systemic. **Oral and Dental Diagnosis** is in the same class with Thoma's excellent books on Oral Pathology, and Oral Surgery. This is a very easy reading text which should be in every dental library.

The Business Side of Medical Practice: By Theodore Wiprud, Executive Director and Secretary of the Medical Society of the District of Columbia and Managing Editor of the Medical Annals of the District of Columbia. Second Edition. 232 pages with 22 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$3.50.

This volume covers all of the phases of medical practice; records, investments, insurance, public speaking, testimony in court, community and medical leadership, medical writing and all. The value of this book to all practitioners, especially to the young man entering into his own practice, can not be overemphasized. The author writes from an active association with physicians of over fifteen years, an association which has brought to the medical societies he has served efficiency, initiative and enthusiasm in organization activity.

Current Therapy 1949—Latest Approved Methods of Treatment for the Practicing Physician: By Howard F. Conn, M. D., Editor. Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. 672 pages. Philadelphia & London: W. B. Saunders Company, 1949. Price \$10.00.

The authors approach therapy from a new viewpoint: the best possible single method of treatment for the specific disease. Should more than one method be acceptable, separate articles are presented. Typographically, this is an excellent work with two columns to the page of readable type. This should be of much help to practicing physicians.

Surgical Pathology: By William Boyd, M. D., Dipl. Pysch., M. R. C. P. Ed., F. R. C. P. Lond., LL.D. Sask., M. D. Oslo, F. R. S. C., Professor of Pathology, The University of Toronto, Canada Sixth Edition. 858 pages, with 530 illustrations, including 22 color figures. Philadelphia and London: W. B. Saunders Company, 1947. Price \$10.00.

Re-written in its sixth edition, this volume serves well as an introduction to pathology for medical students. **Treatment in General Practice:** By Harry Beckman, M. D., Professor of Pharmacology, Marquette University School

of Medicine, Milwaukee, Wisconsin. Sixth Edition. 1,129 pages. Philadelphia & London: W. B. Saunders Company, 1948. Price \$11.50.

This is the general practitioners' "stand-by", a complete text on treatment revised to include therapeutic advances.

Internal Medicine in General Practice: By Robert Pratt McCombs, B. S., M. D., F. A. C. P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. Second Edition. 741 pages with 122 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price \$8.00.

The author emphasizes diagnosis by presenting differential diagnosis in outline. Pertinent illustrations and technics are furnished. The subject has been handled in a concise, clear manner.

Minor Surgery: By Frederick Christopher, B. S., M. D., F. A. C. S., Associate Professor of Surgery at Northwestern University Medical School, Chief Surgeon, Evanston (Illinois) Hospital. Sixth Edition. 1058 pages, 937 illustrations on 595 figures. Philadelphia & London: W. B. Saunders Company, 1948. Price \$12.00.

Many physicians use this standard text as a desk volume. It is presentation of the surgical conditions which confront the general practitioner as well as the surgeon. Its appearance in a sixth edition testifies to its acceptance by the profession.

Modern Clinical Psychiatry: By Arthur P. Noyes, M. D., Superintendent, Norristown State Hospital, Norristown, Penna. Third Edition. 525 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price \$6.00.

This is a worth-while text for teaching purposes, largely re-written in this revised edition.

Pharmacology, Therapeutics and Prescription Writing—For Students and Practitioners: By Walter Arthur Bastedo, Ph. G., Ph. M. (Hon.), M. D., Sc. D. (Hon.), F. A. C. P., Consulting Physician, St. Luke's Hospital, N. Y.; St. Vincent's Hospital, Staten Island, and the Staten Island Hospital; President, U. S. P. Convention 1930-40; Member Revision Committee, U. S. P. Formerly Curator of the N. Y. Botanical Garden; Attending Physician, City Hospital, N. Y.; Instructor in Pharmacology, Cornell University; Associate in Pharmacology and Therapeutics and Assistant Clinical Professor of Medicine, Columbia University. Fifth Edition. 840 pages, with 82 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price \$8.50.

The fifth edition of this reference book maintains its well-established record of evaluating in comprehensive manner the therapeutic values of the commonly employed drugs.

Practical Aspects of Thyroid Diseases: By George Crile, Jr., M. D., F. A. C. S., Department of Surgery, Cleveland Clinic. 355 pages with 101 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$6.00.

Crile appraises thyroid disease in a compact, readable text basing his conclusions on extensive clinical experience. Of particular interest is his personal experience with radioactive iodine and thiourea derivatives which extends over four hundred cases.

Operative Gynecology. By Harry Sturgeon Crossen, M. D., and Robert James Crossen, M. D. Sixth Edi-

tion. Pp. 999. 1,334 illustrations. Price \$15.00. St. Louis: C. V. Mosby Company, 1948.

This excellent textbook reflects the accumulated experience of the authors and discusses not only their own procedures but other operative technics. It will be frequently consulted by the physician interested in gynecology.

Medical Writing, the Technic and the Art. By Morris Fishbein, M. D., Editor, The Journal of the American Medical Association, with the assistance of Jewel F. Whelan, Assistant to the Editor. Second edition. Pp. 292. Price \$4.00. Philadelphia: The Blakiston Company, 1948.

The second edition of this guide for those who write for medical literature has been expanded and may be followed throughout in confidence that manuscripts so prepared will be in acceptable form for medical publications.

Obstetric Analgesia and Anesthesia—Their Effects Upon Labor and the Child: By Franklin F. Snyder, M. D., Associate Professor of Obstetrics and Associate Professor of Anatomy, Harvard Medical School. 401 pages with 114 figures and 18 tables. Philadelphia & London: W. B. Saunders Company, 1949. Price \$6.50.

The tremendous importance of anesthesia and analgesia in childbirth is the subject of this well-written volume. The book does not attempt to present technics of analgesia or anesthesia but rather seeks to explain respiratory injuries to the child and the treatment of pain during labor as related to analgesia and anesthesia.

Physical Diagnosis: By Ralph H. Major, M. D., Professor of Medicine, The University of Kansas, Kansas City, Kansas. Third Edition, Revised. 444 pages with 458 illustrations. Philadelphia and London: W. B. Saunders Company, 1945. Price \$5.00.

This is a standard text on physical diagnosis and follows well accepted standards of the art of diagnosis by physical examination.

A Manual of Pharmacology—And Its Application to Therapeutics and Toxicology: By Torald Sollmann, M. D., Professor Emeritus of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland. Seventh Edition. 1,132 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price \$11.50.

Briefly but in sufficient comprehensiveness are proven drugs presented in this standard text. This is the excellent work on pharmacology available to physicians and deserves a place in the physician's reference library.

A History of the American Medical Association, 1847-1947: By Morris Fishbein, M. D., with the Biographies of the Presidents of the Association by Walter L. Bierring, M. D., and with Histories of the Publications, Councils, Bureaus, and Other Official Bodies. 1,226 pages. Philadelphia and London: W. B. Saunders Company, 1947. Price \$10.00.

This is a volume of which American medicine may be justly proud and Morris Fishbein is deserving of appreciation for his effort. The source material has been carefully and painstakingly studied and presented for the enjoyment of the reader. We commend this as a book to read and re-read.

Gifford's Textbook of Ophthalmology: By Francis H. Adler, M. D., Professor of Ophthalmology, University of Pennsylvania Medical School. Fourth Edition. 512 pages, with 310 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price \$6.00.

This is a completely revised edition of the book which

has been well received for many years. Dr. Adler, in clear style, has presented a review of common ophthalmologic problems especially suited to physicians who are not ophthalmologists.

Blood Transfusion: By Elmer L. DeGowin, M. D., Associate Professor of Internal Medicine, State Univ. of Iowa; Robert C. Hardin, M. D., Assistant Professor of Internal Medicine, State Univ. of Iowa; and John B. Alsever, M. D., Senior Surgeon, U. S. Public Health Service. 587 pages with 200 diagrammatic drawings. Philadelphia and London: W. B. Saunders Company, 1949. Price \$9.00.

This book will prove of value to physicians interested in therapy with blood and plasma and who are concerned with the management of blood banks. This is the most satisfactory text available on the subject of blood transfusion.

Peripheral Vascular Disease: By Edgar V. Allen, B. S., M. A., M. D., M. S. in Medicine, F. A. C. P., Division of Medicine, Mayo Clinic, Assoc. Prof. Medicine, Mayo Foundation, Graduate School, Univ. Minnesota; Diplomate of the American Board of Internal Medicine; and Nelson W. Barker, B. A., M. D., M. S. in Medicine, F. A. C. P., Division of Medicine, Mayo Clinic, Assoc. Prof. Medicine, Mayo Foundation, Graduate School, Univ. Minnesota; Diplomate of the American Board of Internal Medicine; and Edgar A. Hines, Jr., M. D., B. S., M. A., M. S. in Medicine, F. A. C. P., Division of Medicine, Mayo Clinic, Assoc. Prof. Medicine, Mayo Foundation, Graduate School, Univ. Minnesota; with Associates in the Mayo Clinic and Mayo Foundation. 871 pages, with 386 illustrations, 7 in color. Philadelphia and London: W. B. Saunders Company, 1946. Price \$10.00.

Present-day knowledge of peripheral vascular disease is well presented in this volume which will be a necessity to internists and practitioners especially concerned with circulatory diseases.

Sexual Behavior in the Human Male: By Alfred C. Kinsey, Professor of Zoology, Indiana University; Wardell B. Pomeroy, Research Associate, Indiana University; and Clyde E. Martin, Research Associate, Indiana University. 804 pages—173 charts—159 tables. Philadelphia and London: W. B. Saunders Company, 1948. Price \$6.50.

This is a most unusual and significant book: a study of the sexual habits of American men prepared by Kinsey and associates at Indiana University after years of research. It is certain to provoke controversy as to facts established and opinions proffered. Its acceptance by the laity would seem to indicate that the profession has not perhaps served well as counselor in the field of sexual relations. Morals are not discussed. There is no "right-or-wrong" attitude. This book deserves careful and studious reading by physicians as well as laymen.

Diseases of Metabolism—Detailed Methods of Diagnosis and Treatment—A Text for the Practitioner: Edited by Garfield G. Duncan, M. D., Director of Medical Division, Pennsylvania Hospital; Clinical Professor of Medicine, Jefferson Medical College, Philadelphia. Second Edition. 1,045 pages, with 167 figures. Philadelphia and London: W. B. Saunders Company, 1947. Price \$12.00.

Various phases of metabolism receive separate chapter treatment in this volume by acknowledged authorities. This text will be of interest to the practitioner who seeks information on laboratory experimentation in its relation to clinical medicine.

Handbook of Materia Medica Toxicology and Pharma-

cology: By Forrest Ramon Davison, B. A., M. Sc., Ph. D., M. B. Consultant and Toxicologist, Minneapolis, Minnesota; Formerly Assistant Professor of Pharmacology, University of Arkansas School of Medicine and Assistant Professor of Pharmacology, University of Tennessee School of Medicine. 704 pp., 35 illustrations, \$8.50. 1949. The C. V. Mosby Co., St. Louis.

In this, the fourth edition of Dr. Davison's book, the general features of previous editions are retained. There are twenty-three chapters or divisions arranged in logical sequence. There are 35 figures illustrating facts pertinent to the topic being discussed. As in previous editions 30 of these are from Jackson's valuable book on Experimental Pharmacology and Materia Medica.

The 700 pages of the book contain much more information than the term "Handbook" would lead one to conclude. By the use of fine print the publishers have been able to utilize 55 lines to the page, thus making the information available comparable to that of many standard texts in the field. The book summarizes the salient features of most of the drugs of medical interest. An attempt has been made to keep abreast of the rapid developments in the fields covered. The chapter on Toxicology has been enlarged and includes the new advances in the diagnosis and treatment of poisoning. Of particular value also are the chapters on anti-infectives which include discussions of important new agents such as streptomycin, aureomycin, bacitracin, paludrine and chloroquine.

Several mistakes unfortunately appear and mar the value of this well organized work.

Psychiatry in General Practice: By Melvin W. Thorner, M.D., D.Sc., Assistant Professor of Neurology, The Graduate School of Medicine, University of Pennsylvania. 659 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price \$8.00.

This is a most interesting volume and brings the general practitioner in readable form, shorn of verbosity usually attendant upon the subject, an appreciation of the part that psychiatry plays in every-day practice. Typical case histories serve well to illustrate the applications of the specialty.

REPORTS OF MEDICAL EXAMINATIONS FOR VETERANS ADMINISTRATION RATING AGENCIES

The National Rehabilitation Commission of The American Legion wishes to call to the attention of the medical profession that many veterans who are attempting to get disability claims adjudicated before Veterans Administration rating agencies are experiencing delays and handicaps in accomplishment of final rating because of physicians' reports and statements which are unsatisfactory or not acceptable to the Veterans Administration for one reason or another. The purpose of this statement is to clarify what the Veterans Administration desires of physicians' reports to adjudicate claims properly. The Veterans Administration regulations require that the physician's statement be notarized only in initial establishment of service connection for a specific disease or condition. While this requirement is considered a waste of time by most physicians,

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requires more strenuous measures. . . . Aminophyllin in doses of 0.25 Gm. dissolved in 10 cc. of water is often very effective when injected intravenously."¹

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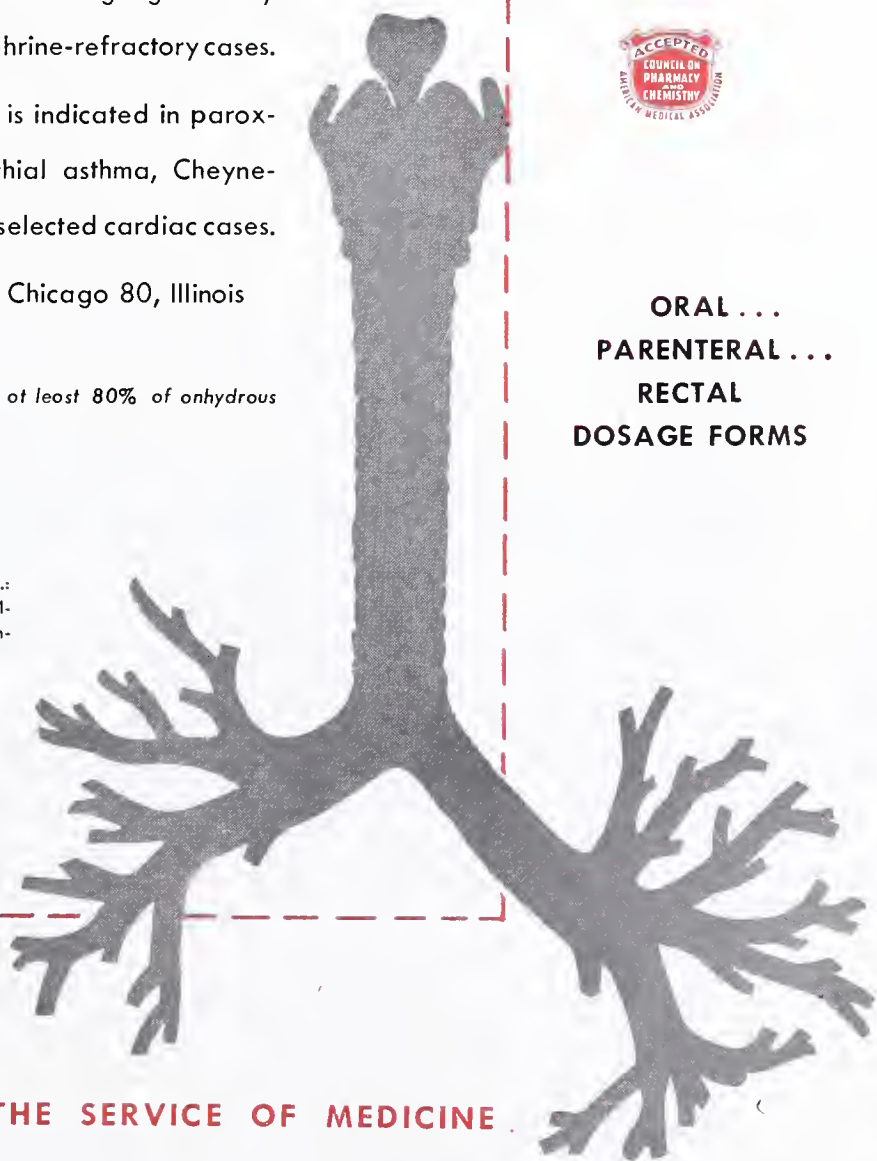
G. D. Searle & Co., Chicago 80, Illinois

*Searle Aminophyllin contains at least 80% of anhydrous theophylline.

1. Rackemann, F. M., in Cecil, R. L.: Textbook of Medicine, ed. 7, Philadelphia, W. B. Saunders Company, 1948, p. 539.



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it is a Veterans Administration requirement in establishing initial service connection. However, most doctors will be examining and working on reports for veterans who have already had service connection established, and are conducting the examination to determine whether the condition has improved, regressed or remained stationary. In such cases, the statement on the physician's letterhead is sufficient. Notarization is not required in these cases.

Since claims may be made months, or, in some cases, years after the physician has examined or treated the veteran for a given condition, the doctor should state in the body of his report whether the information is from his office or clinic records, or from memory. Since Veterans Administration adjudication personnel have among their number physicians, or they can obtain the advice of Veterans Administration doctors, the reports should be in professional language with no attempt to simplify the terminology for lay interpretation. Interpretation of the validity of the doctor's data in relation to the veteran's claim will be made by medical personnel. Therefore the reports should be as complete and detailed as possible.

In the report, the date of first treatment and

the length of time the veteran has been observed by the doctor should be included. Details of the pertinent history and physical examination are essential. The detailed medical findings, both physical and laboratory, should be included. For instance, degree of extension or flexion of an ankle may be very important in determining adjudication results. Such detailed medical findings should be listed by the reporting physician. When this is done, the final diagnosis made by the doctor can be interpreted in the light of the data that led to the making of the diagnosis. It is not sufficient merely to state that the veteran was treated for a given condition, without giving some of the pertinent facts relative to the condition in the particular veteran. If laboratory tests or roentgenologic or other special examinations are done, reports of these should be included, if such reports are available. Some of these data may be valuable to aid the Veterans Administration in establishing the merit of a veteran's claim.

In summary, the medical report for the veteran for adjudication purposes should be complete and as detailed as possible. History, physical examination, laboratory and special examinations, with dates of period of observation and performance of examinations, are desired.

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The JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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FORT SMITH, ARKANSAS, SEPTEMBER, 1949

No. 4

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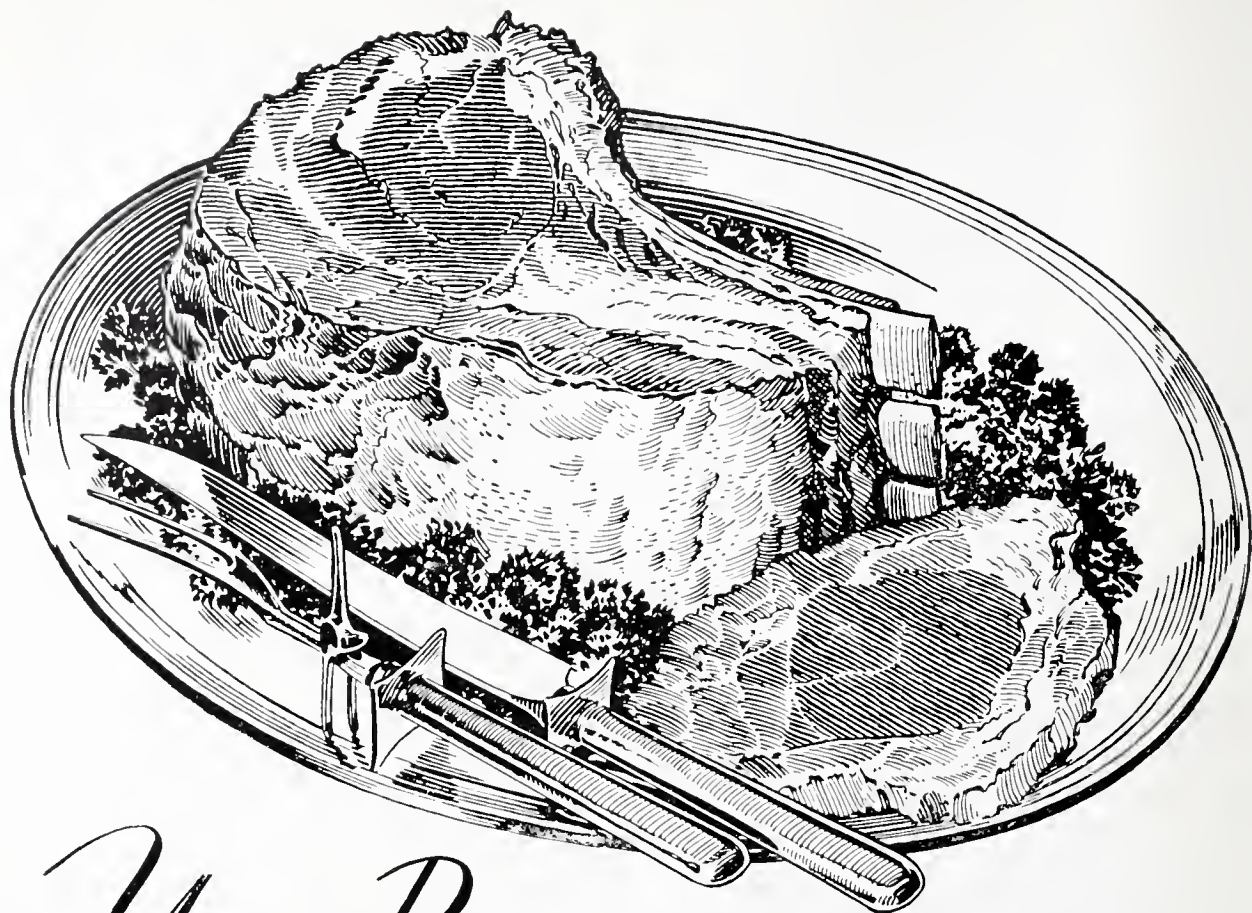
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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (April 2) 1949.



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The JOURNAL

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Vol. XLVI

FORT SMITH, ARKANSAS, SEPTEMBER, 1949

No. 4

TREATMENT OF A CASE OF ENDEMIC TYPHUS WITH CHLOROMYCETIN *

ROBERT F. McCrARY, M.D.

Endemic or Murine Typhus is rather prevalent in the United States, particularly in the southeastern section where, from 1939 to 1942, 15,933 cases were reported (1). In 1948, six cases of endemic typhus were reported in Arkansas, and in 1949, three cases have been reported to date (2). (Figures as of week ending 9 July 49.)

Endemic typhus may be carried from rat to rat by the rat louse; and, from rat to man, the probable vector is the rat flea. Animals may be infected with murine typhus by feeding on material containing the rickettsi. In the south, the incidence of this disease is two to one more common in males (3).

Endemic typhus is a severe febrile disease of about fourteen days' duration and is caused by the *Rickettsi Mooseri*. The onset may be gradual or abrupt following an incubation period of six to fourteen days. The fever rises to 102 to 105 degrees Fahrenheit during the first week and remains elevated until about two weeks after the onset. The rash, usually limited to the chest, abdomen, and inner surfaces of the arms, resembles that of epidemic typhus with the exception that petichiae are rare. The macules, appearing about the fifth day, at first fade on pressure but soon lose that character. After two to ten days they disappear (4). The temperature usually falls by rapid lysis, recovery being complete, although convalescence may be delayed. Mental symptoms are not marked and complications are rare.

The pathology of endemic typhus is not too well described because of the low mortality rate of 5 per cent, but it is known that the rickettsiae of the typhus group are found in the endothelium of the blood vessels and in the macrophages which make up the perivascular reaction but not

elsewhere. Presumably, these organisms never invade the smooth muscle cells and the connective tissue cells of the media, and, therefore, they give rise to no striking necrosis of the walls of the vessels, such as is typical of the lesions of the spotted fever group (5).

The diagnosis of murine typhus presents problems similar to those of epidemic typhus. Serologic reactions and animal inoculation must be depended upon to distinguish this disease from other rickettsial infections. The Weil-Felix test does not differentiate murine typhus from epidemic typhus or Rocky Mountain Spotted Fever. Complement fixation, however, is highly specific for each of these diseases.

The case reported is that of a fourteen year old white male, D.V., who was in good health until 13 June 49, at which time he had a sudden onset of headache, chilliness, nausea, abdominal pain, pain in the muscles of legs and back, and fever of 104 degrees. Symptoms were continuous and gradually grew worse until he was seen by the writer on 14 June 49. At this time, symptoms were as stated except that the pain in the abdomen was less, and patient had had two to three loose stools.

Past history revealed the child had had the usual childhood diseases with the exception of measles. He had had no previous serious illness. Drinking water was city supplied and milk came from a local grade A dairy and was pasteurized. The patient had been inoculated for smallpox, typhoid fever, whooping cough, diphtheria; however, typhoid inoculation had not been repeated in six years. Past history also revealed that twelve to fourteen days prior to present illness, patient had been visiting in Louisiana where a friend had become ill with the measles, and patient had also been bitten by a mouse. Close questioning revealed it to be a mouse and not a rat. Other past history was entirely negative.

Initial physical examination revealed a well developed, well nourished fourteen year old white male, acutely ill, lying quietly in bed, alert men-

* From the Department of Medicine, Wade Clinic, Hot Springs National Park, Arkansas.

tally, and cooperative. Weight was 98 pounds, height was 54 inches, and temperature was 104 degrees.

EENT: Ears negative, nose negative, eyes revealed a mild conjunctivitis, and throat red and injected. No Koplick spots were present. There was a post-cervical lymphadenopathy present.

CHEST: Respiration was 22. Expansion was bilateral and equal. Chest was resonant to percussion. Vocal fremitus normal and whispered pectorliqy was normal. Breath sounds were normal. No rales were audible.

HEART: Blood pressure was 120/80. Point of maximum impulse was in the fifth left interspace at the mid-clavicular line. Normal sinus rhythm. Rate was regular. Heart sounds were normal. No murmurs were audible.

ABDOMEN: Normal in contour. No distention. There was tenderness in left upper quadrant and midline. No muscle guarding or rigidity. Liver, kidneys or spleen were not palpable, and there were no masses palpable. No hernia.

NEUROMUSCULAR: Extra-ocular movements were normal, no weakness or paralysis of musculature. Normal range of motion in each joint.

REFLEXES: Reflexes were present and active bilaterally. No abnormal reflexes were noted. Romberg and Babinski were normal. Patient was mentally alert.

SKIN: Clear. No rashes or discolorations. Mucous membranes normal.

GLANDS: No lymphadenopathy noted except as stated above.

Symptomatic therapy was instituted at this time. Patient was again seen on 15 June 49, with symptoms and physical examination exactly the same. Again the patient was seen on 16 June 49, at which time temperature was 105 degrees, an enlarged spleen was noted, and a faint masclar type rash was noted on the inner aspect of both arms. This rash disappeared some six hours later and did not reoccur during the course of illness. At this time, blood count, urine, agglutinations, Widal, stool, and blood cultures were done.

Blood Count: R.B.C., 4,980,000; W.B.C., 3,200; Hemoglobin, 14.5 grams or 96%; Differential: Lymphs 52, Polys 47, Eos. 1.

Urine: Specific Gravity, 1.005; Color, lemon;

Reaction, acid; Albumen, faint trace; red blood cells, white blood cells, and bacilli, negative.

Widal, stool culture, blood culture, urine culture and agglutinations were all negative.

The patient was seen daily thereafter, receiving only symptomatic treatment until on 20 June 49. During this interim, he continued to have fever of 102 to 105, headache, tenderness in left upper quadrant, progressive weakness and enlarged spleen. On the 20 June 49, blood count revealed R.B.C., 4,690,000; W.B.C., 3,600; Hemoglobin, 13.5 grams or 90%; Differential: Lymphs 54, Polys 44, Eos 2. Repeat agglutinations revealed *P. Tularensis*, negative; *Brucella Abortus*, negative; *Proteux O*19, positive 1.320; Typhoid O and H, negative; Paratyphoid A and B, negative.

At this time, a positive diagnosis of endemic or murine typhus was made. At 6:00 P. M. on 20 June 49, patient was started on Chloromycetin in the recommended dosage of 60 mgm/kilo of bodyweight at initial dose and then 0.25 gm. every three hours until patient was afebrile. Initial dose was divided into three capsules every thirty minutes for four doses. At 11:00 A. M. on 21 June 49, patient was afebrile, subjective symptoms had disappeared, but the spleen was still palpable.

Chloromycetin was discontinued as recommended by the manufacturers. Patient remained afebrile and asymptomatic until 22 June 49 between 1:00 and 2:00 P. M., at which time the symptoms of headache, malaise, leg pain, and temperature of 104 degrees reappeared.

Chloromycetin in initial dosage of 60 mgm/kilo was restarted and 0.25 gm. was given every three hours until the patient was afebrile thirty-six hours. On 23 June 49 at 9:00 A. M., patient was completely asymptomatic, afebrile, and remained so until the conclusion of therapy some thirty-six hours later. Patient had a total dosage of 10 gm. of Chloromycetin.

Patient was again seen on 3 July 49, at which time the physical examination was entirely normal and agglutination for *Proteus O*19 was 1-320. A repeat agglutination for *Proteus O*19 one month after onset of present illness revealed it to be 1-640. At this time, patient was completely asymptomatic and in excellent health.

Chloromycetin is a pure, crystalline substance having specific antibiotic activity. This new antibiotic, obtained from cultures of the specis

Streptomyces Venezuelae (6), can also be prepared synthetically. Chloromycetin has been found to be effective against an impressive range of micro-organisms including typhoid fever, other salmonella infections, bacillary urinary infections and diseases in which the rickettsias are etiologic factors.

The clinical studies of Chloromycetin and its use against typhus was initiated by Payne, Knaudt, Papacios (7). Preliminary results of the work of these investigators in Bolivia were reported before the La Paz Medical Society and offered confirmation to the encouraging results previously found experimentally by Ehrlich, Bartz, Smith, and Joslyn (8).

SUMMARY AND CONCLUSIONS

1. Endemic typhus fever is prevalent in the Southern United States.
2. Endemic typhus fever is transmitted by the rat with the rat flea being the probable vector in man.
3. Positive diagnosis of endemic typhus fever can be made by complement fixation test.
4. Chloromycetin is an effective antibiotic in the treatment of endemic typhus fever.
5. Chloromycetin is apparently non-toxic in large dosages in children.
6. Chloromycetin will not mask the agglutinations for *Proteus O*19.
7. It is the opinion of the writer that in this case, and probably other cases of endemic typhus fever, Chloromycetin should be given at least twenty-four hours after the patient becomes afebrile.

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HEMATURIA: ITS CLINICAL SIGNIFICANCE *

J. FRANK CLARK, M. D.

El Dorado

Hematuria is one of the more frequent symptoms of disease of the genito-urinary tract. Its importance is frequently underestimated by the patient and too often by the physician.

Gross hematuria usually evokes one of two responses in both patient and physician. The more intelligent patient becomes duly alarmed and promptly consults his physician; the less intelligent patient will pay scant heed to this symptom or will disregard its entirely. The intermittent appearance of blood in the urine will lull this patient into a false sense of security; he will seek medical aid only when the hematuria has persisted for several months or years and at a time when it is difficult or impossible to cure.

Physicians likewise respond in one of two ways. The more enlightened or conscientious physician will realize that hematuria denotes the presence of a pathologic lesion in the urinary tract and that it is his responsibility to determine the source of the blood; to fulfill his responsibility, the physician will either carry out a careful urologic investigation or advise that such an investigation be made. The less conscientious physician will, without adequate investigation prescribe some drug hoping that the hematuria will cease, which it frequently does, only to reappear again.

MacKenzie (1932) reported on a series of cases studied at the Royal Victoria Hospital in which he showed that 20.24% of urological admissions passed bloody urine, and that in 75% of the cases the blood was caused either by tumor, infection, calculus or nephritis. In 96% of the cases with hematuria a causative lesion was found within the urinary tract and over 40% of these lesions were neoplastic.

In somewhat similar reports by Higgins, by Kretschmer, by Lower, it has been shown convincingly that when blood appears in the urine it is serious symptom and its source and cause should be ascertained even though it may involve extensive physical and laboratory tests. In almost a third of 798 cases reviewed by Lower, hematuria was caused by neoplasma involving the urinary tract, calculus was found in 16% and tuberculosis in 11%. In other words 59% of these cases of hematuria resulted from causes

* Read before the Seventy-Third Annual Session, Arkansas Medical Society, Little Rock, April 16, 1949.

which could be relieved in most instances by early treatment.

Every case of hematuria presents two important questions which must be answered; first, from what part of the urinary tract is the bleeding coming, and secondly, what is the underlying nature of the disorder which is responsible for the bleeding? Cases of gross or microscopic blood in the urine may be divided into four groups. (1) Those in which the bleeding is due to some systemic disease; (2) Those due to urogenital lesions and local causes within the urinary tract, which comprise 75% of the cases; (3) Those in which bleeding is caused by invasion or disease from adjacent structures, and (4) those produced by trauma, including foreign bodies. Among the systemic conditions are the blood dyscrasias, such as leukemia, hemophilia, Hodgkins disease, etc.

The acute fevers as scarlet fever, measles, septicemia; the chemical agents as sulfonamides, mercury, turpentine and lead poisonings; and the vitamin deficiencies such as scurvy and deficiency in vitamin K. In those cases in which bleeding occurs as a result of extraurinary tract pathology adjacent to the genito-urinary system, inflammatory or neoplastic disease of the cervix, uterus, sigmoid or rectum are the most common. Malignancy of the cervix not infrequently invades the bladder or ureters. The same is true of a malignancy of the sigmoid or rectum extending into the bladder. Granuloma inguinale frequently extends from the anus and rectum and invades the bladder resulting in hematuria and a subsequent fistula formation.

Appendiceal lesions, either abscess or retrocecal appendicitis, cause hematuria. Therefore, rectal and vaginal examinations routinely on physical studies are important.

Local or urogenital lesions are the most frequent cause of serious bleeding and may be grouped under five principal headings in the order of relative frequency:

- (A) General infections
- (B) Neoplasms
- (C) Tuberculosis
- (D) Trauma from stones or other causes
- (E) Nephritis

Cases due to these conditions comprise about 75% of the total. Much may be gained from a carefully taken history in these cases. The patient's own observations of the amount of blood passed, its appearance during the course of micturition, *i. e.*, whether initially or terminally, or throughout the act of voiding, or whether there is pain, dysuria or urinary fre-

quency accompanying the bleeding, is most important. For example bleeding of a painless nature, short duration and long intervals is likely to accompany tumor of the kidney. Other symptoms are often associated with hematuria. Painful voiding, bladder irritation, loss of weight, chills and fever, and the presence of a mass are important clues. Renal colic may mean a stone or blood clot passing down the ureter, pain in the back or loin usually signifies a kidney lesion. Retention of urine and signs of bladder irritation such as frequency and burning, point to the bladder as a source of the hematuria. Acute bladder distress with terminal drops of blood and marked frequency along with a febrile course might signify acute cystitis, trigonitis or pyelonephritis. Prostatic bleeding is very common, and to the surprise of many, the benign prostatic enlargement bleeds more often than the malignant one. The reason for prostatic bleeding is that there is chronic irritation and infection protruding portions of the prostate. When renal or ureteral calculi are present, there is usually colic like pain and blood in the urine. A bloody urine which appears initially during the voiding act usually originates from the posterior urethia. When the bleeding is painful, it is usually vesical. Of course the time to check on these hematuria cases is while they are bleeding. In the majority of cases, the bleeding point may be visualized. Obviously, in a copious painless hematuria of a short duration, early and prompt diagnosis and prompt treatment is important. Even though the bleeding has ceased when the patient is seen a detailed survey is warranted. Early diagnosis and prompt treatment offer the only chance of cure in malignancies of the genito-urinary tract.

Even after trying to evaluate or classify these patients from their history and type of bleeding, too much dependence should not be attached to the history, because all patients must be thoroughly checked or disaster may result.

When microscopic blood is found on routine urinalysis, although the patient may be asymptomatic, urinalysis should be run at intervals and if the cells persist, this warrants a complete urological survey.

For many years past, patients with hematuria in whom no cause could be found to explain the condition were given the diagnosis of essential hematuria. Now, with better diagnostic instruments, the diagnosis of essential hematuria is seldom, if ever, justified. It would be better to employ the term hematuria of undetermined origin in those few instances where a thorough

examination fails to reveal the cause of the hematuria. In this group the factors responsible for the bleeding may have disappeared by the time the patient comes under observation, such as a small stone which has been passed or an infection which has cleared spontaneously. However the most frequent cause is a ruptured capillary in the renal papilla or hemosioma of a renal papilla. However hemosioma usually bleed more profusely, and frequently necessitates nephrectomy because of the profuse hemorrhage. After a complete history, physical, blood and urine examinations on the patient, the next step in diagnosis is cystoscopic examination; however a flat KUB film and intravenous urography have proved of great value as a preliminary survey of the urinary tract, this study, however should always be followed by a cystoscopic examination to confirm the presence of surgical lesions, as excretory urography is not conclusive when used alone. In the diagnosis of such diseases as tuberculosis, neoplasms, hydro-nephrosis, and obstruction, retrograde pyelography is necessary to delineate the finer parts. After cystoscopic examination, ureteral catheterization with complete bacteriological and sediment examination from each kidney for casts, pus cells, blood, etc. If it is thought necessary, slides may be made for cystologic test, using Papanicolaou technique; there are many reports in the literature of early neoplasms being picked up in this manner. Gram stains and examination for tubercle bacilli are important. Guinea pig inoculation or culture is necessary if tuberculosis is suspected. Much evidence often can be gained from a cystourethrogram, using rayopake. The X-rays will visualize deformities in the vesical and urethral outline such as diverticulae, prostatic hypertrophy and tumors of much size.

Cystoscopy should be carried out during the bleeding phase if possible. In many cases the only way in which the source of bleeding can be determined is by observing the jet of bloody urine coming from the ureteral orifice on the involved side. If, on cystoscopic examination a lesion is found in the bladder, the examination should not be terminated at that point since concomitant lesions may be present in the upper urinary tract. Tumors of the pelvis and ureter are often associated with implants in the bladder.

Treatment would involve a consideration of all urology; therefore I will not go into treatment.

However in closing I do wish to repeat the following, to remember that bloody urine is due to a broken or ruptured blood vessel some

where in the urinary tract. This may not always be easy to find, but endeavor to locate that vessel by following a definite pattern of diagnosis and then treat the disease. Do not give penicillin, streptomycin, sulfa drugs, mandelic acid, or some other urinary antiseptic until a diagnosis has been established. Treatment before an accurate diagnosis has been made may only alleviate the symptoms and allow the pathological condition to progress.

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CORRESPONDENCE

July 1, 1949

Dr. W. R. Brooksher, Secretary
Arkansas Medical Society
Fort Smith, Arkansas
Dear Doctor Brooksher:

The State Health Department has, effective July 1, 1949, revised the salary ranges for physicians employed as medical directors for county and district health departments.

There are two positions classified. First, that of Junior Medical Director, requiring graduation from a school of medicine and internship approved by the Council on Medical Education and Hospitals of the American Medical Association, eligibility for license to practice medicine in Arkansas, and not over 40 years of age when first employed in full-time public health work. The salary range for this position is \$5,100-\$5,700 per annum. Second, that of Medical Director, which requires, in addition to the above a Master's Degree from a school of public health recognized standing and at least three years of experience in the active practice of medicine, of which at least two years within the past ten shall have been full-time in an administrative position in public health. The salary range for this position is \$6,000 to \$6,900 per annum.

We would appreciate very much having this information published in the Journal.

Sincerely yours,

T. T. ROSS, M.D.
State Health Officer

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EDITORIAL

A ONE-SENTENCE EDITORIAL

What the public thinks of the medical profession is YOUR responsibility.

REORGANIZATION PLAN NUMBER ONE

President Truman submitted to the Congress on June 20th various reorganization plans in accordance with law, among which was Plan No. 1 which would have created a Department of Welfare with cabinet status. Briefly stated this plan merely elevated the Federal Security Administration and increased the powers of its administrator. Proponents of the change contended that the functions of education, health and security now performed by the Federal Security Administration were of sufficient importance to warrant departmental status, that the plan would implement a cardinal recommendation of the Hoover Commission, that the authority of the administrator would become more effective and

that "prestige" would accrue by elevation of the Federal Security Agency to departmental status, thereby facilitating more efficient discharge of the functions performed by that agency and its administrator.

With these contentions, the medical profession and supporting citizens disagreed. First of all, the opposition showed that the proposed plan did not conform to the recommendations of the Hoover Commission in that it omitted the Commission's recommendation relating to the consolidation of all major Federal health facilities in a proposed independent United Medical Administration. The reorganization plan would obviously destroy the degree of independence which the U. S. Office and Education and the U. S. Public Health Service have at this time. The Secretary of the proposed department would have complete control over all functions of the department and would have actual domination over the administration of the health, education and welfare activities of the Federal government. It was contended that any prestige which might accrue to such a department would but serve to add the so-called prestige to the propaganda now exerted by the agency for compulsory health insurance. The long-voiced demand of the medical profession for a separate Department of Health with a physician as its secretary head was, of course, ignored in the plan.

With the announcement that the Committee on Expenditures in the Executive Departments, Senator John L. McClellan, Arkansas, Chairman, would hold hearings on this proposed reorganization plan, state medical societies became increasingly active in making known their opposition to the proposed plan. The Arkansas Medical Society took early lead in this effort and was ably supported by other state societies, notably Oklahoma, Texas and Kansas.

J. J. Monfort, Batesville, appeared before the Committee for the Arkansas Medical Society July 22nd and presented the viewpoint of the physicians of Arkansas. His testimony was effective and favorably received by the Committee. Because of the interest aroused, particularly in western states, physicians personally called on their Senators in Washington to discuss the medical profession's opposition to the proposed plan. President-elect Earle H. Hunt represented Arkansas in this visit to Senators at Washington. They were welcomed by members of the Senate and their discussions were given utmost consideration.

Senator J. W. Fulbright, Arkansas, with the co-sponsorship of Senators Hunt, Ohio, and Hunt,

Wyoming, introduced the necessary resolution disapproving the plan, S. 147, in the Senate July 29th. The committee voted 7 to 4 approval of the resolution on August 5th and on August 16th after prolonged debate, the Fulbright resolution was adopted by the Senate, 60-32, thus defeating the proposed reorganization plan as submitted by the President.

The Arkansas Medical Society is appreciative of the leadership, courage and intense interest which this legislation received in the Senate. In particular, it is proud to know that Senators McClellan and Fulbright were personal leaders in the legislative conflict which resulted in defeat of the resolution.

The comments of Senator McClellan at the close of the committee session July 22nd relative to so-called "Lobbying" on the part of the medical profession are of interest and are quoted: "Supplementing your statement, Senator (Schoepel, Kansas), if I may suggest that the folks who condemn what they term lobbying by the American Medical Association, by farmers' organizations, and by business interests, are usually the ones we find lobbying in the Federal government. When they object to what they term a slush fund provided by individual citizens who contribute out of their own pocket, we often find they are using the taxpayers' money to disseminate the propaganda that serves their philosophy. So when I hear lobbyists condemned, my first thought turns to some agencies of the Federal government."

RANDOM THOUGHTS OF THE SECRETARY

July 20th. Press dispatches report that Sir Stafford Cripps has gone to Scotland and Bevin to Europe for their health. The marvelous British scheme of nationalized medicine must have some drawbacks.

July 21st. With the Presidential Understudy, Earle Hunt, to Lake Atalanta, where the Benton county group provides another gala picnic session in the annual Benton-Washington county custom and enjoyment is full and complete for the afternoon.

July 22nd. All we know is what we read in the papers which today report that Little Rock's mayor is going to Washington to get what money he can and thus thrives local autonomy in the affairs of government.

July 28th. For these many days devoting much time and pleading to the cause of impending legislation with indifferent success.

July 29th. For sympathetic attention to the ideals of organized medicine, we feel that Arkansas' representatives in Congress deserve our appreciation in fullest degree. Today Bill Fulbright steps out with a resolution disapproving Reorganization Plan Number One, a necessary step in rejection of this undesirable measure, and to

our Senator we bespeak the gratitude of all of us for an action which took full courage.

July 30th. In the heckling, stimulating company of Henry, Smith and Alstadt by the airways to Denver, but slightly perturbed by the thunderstorm at Raton Pass, and in due course to the Brown Palace's Ship Tavern where we meet Bob Bird, Henry's buddy, and hear "the-story-of-the-month" which presents the matter of free enterprise and profit in an old profession.

July 31st. Once more in cool Colorado this day and afforded a view of the Rockies as we ride from the hotel to the airport: it might be said that scenically this trip was a total loss. Departing Denver with the consciousness that there exists a determination to do the job in many a state, so encouraged withal.

August 7th. Marguerite and Charles Henry come visiting affording opportunity to post-mortem recent events in national legislative scene but mostly for old-fashioned "setting and talking"—a very happy occasion.

August 15th. The state Junior Chamber of Commerce appoints a chiropractor as chairman of its committee on public health!! Do any of the younger physicians take any part in the affairs of this organization?

August 16th. We wonder if the President still thinks what Herbert Hoover says is "funny."

OBITUARY

WILLIAM F. ROGERS, age 81 years, died at Saint Joe August 5th after an illness of two years although he was still in limited practice at the time of his death. A graduate of the University of Arkansas School of Medicine in 1888, he first practiced in Texas but later located in Saint Joe. He was an honorary member of the Masonic lodge and was elected to life membership in the Arkansas Medical Society at the 1949 annual session, at which time the Fifty-Year Pin was awarded him. He is survived by four daughters and one son.

CHARLES C. ANDERSON, age 72, died at his home in Little Rock August 16th. A graduate of the University of Arkansas School of Medicine in 1900 he had practiced continuously in Little Rock until ill health forced his retirement about three years ago. He had been a member of the Pulaski County Medical Society since February 6, 1939. Surviving relatives are his wife and two daughters.

EDWARD O. DAY, Little Rock, age 66 years, died July 20th after a prolonged illness. Born in Kentucky he graduated from the University of Arkansas School of Medicine in 1912. During World War I he served as lieutenant-colonel in the army medical corps. He was a member of the various Masonic bodies and of the American Legion. Surviving are his wife and a daughter.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

TODAY there are thousands of workers whose prime objective is the control of tuberculosis. A method of attaining that objective is known. It consists of finding and persuading each person with tuberculosis to seek medical care and providing his physician with the knowledge necessary to treat the disease effectively. In it is included restoring the individual to the fullest possible usefulness, and protecting others from contagion.

THE PRESENT STATUS OF TUBERCULOSIS CONTROL

The control of tuberculosis involves acquiring new knowledge—research; and distributing existing knowledge—education. Education involves the public and the medical profession. The doctor in his office is impotent unless the patient comes to him. The patient is in jeopardy unless he knows that he is a patient, and unless the doctor knows how to treat him. These principles are inseparable. The physician and the health educator are mutually dependent and inseparable allies in the campaign against tuberculosis.

One of the ways in which the progress of tuberculosis control is being retarded is putting the emphasis upon accomplishments, not upon the unfulfilled tasks. To believe the job is nearly done is dangerous, and the facts should be faced.

Forget about the reduction in tuberculosis mortality statistics for a moment and look at the present situation! Tuberculosis, today in the United States, remains the most important chronic fatal disease to be caused by a "germ," the most important of all diseases of young people, the most important of the truly preventable diseases.

More than this should be said—much more. Mortality statistics list tuberculosis in comparison with groups of other diseases. "Heart disease" is not one disease but many. It includes arteriosclerotic heart disease of the aged, rheumatic heart disease of the young, hypertensive heart disease of middle life, infectious diseases of the heart, and many rarer conditions.

Cancer is not a single disease, presenting one medical problem. Yet the various cancerous diseases are grouped for comparison with tuberculosis. Most cancer appears to be a degenerative disease of older age; most deaths from heart disease are incident to old age. Everyone has to

die some day from some cause and these degenerative conditions will increase as our people live longer and longer lives.

Tuberculosis is also displaced on the list of causes of death by accidental deaths of all types—obviously an unfair comparison. Tuberculosis would rank higher if mortality tables grouped diseases properly. If listed according to preventability, or to age groups affected or to years of potential life lost, or to actual cost in dollars, or according to sorrow, hardship and frustration caused—there would be less complacency and more alarm at the present tuberculosis death rate.

If causes of death were listed according to organs affected, diseases of the lungs would stand high on the list. Diseases such as tuberculosis, asthma, bronchiectasis and pneumonia stand high. Pulmonary embolism and, among males, cancer of the lung are also extremely important.

There has been so much talk about scientific medicine that some people seem to think of medical practice as a technological pursuit—applying fixed formulas to compute the diagnosis. **Medicine is a ministry as well as a science, and the practice of medicine a calling as well as an occupation.**

Patients are people. They have intellect, imagination and emotions—they have souls. No two people react alike to the same disease and few human miseries are caused entirely by pathologic alterations of body structure. Symptoms are almost always caused by a blend of pathology with fear, apprehension, and perhaps fatigue. The majority of persons seeking medical advice have no significant organic disease. Their symptoms are due to misbehaving organs, not diseased organs. These complaints are called

"functional" as distinguished from "organic" or structural defects. But functional complaints are real, not imaginary, and often they are curable. And when organic disease strikes—tuberculosis, heart disease, cancer—the emotional aspects, the functional disturbances are as real and often more disturbing than are the pathologic alterations. Even major surgery is to the normal person frequently more of an emotional than a physical experience.

The modern school of medical practice believes in full and complete instruction of the patient. He not only may, but must know the facts, good and bad. He is not the subject of medical treatment but the partner of his physician and shares the task of achieving recovery. Patients see their X-rays; they know about laboratory tests; they know the diagnoses and something of the future.

The modern physician sees a greater duty than that of restoring to a state of health people who feel ill. He advises normal well people how to remain well, happy, and productive. He is learning how to examine well people and to avert many of the tragedies which occur when his advice is sought belatedly. Through his knowledge of personal hygiene, immunization, nutrition, and the nervous system, he may prevent disease and interpret functional symptoms.

In the prevention of disease the physician has allied himself with public health experts, field workers, and executives. These are trained educators, inspired and diligent crusaders, who not only work beside the physician—they work ahead of him. They make possible the application of his skills and arts to vast numbers of people otherwise beyond the doctor's reach. Physicians should know more of these professional allies and the knowledge and training which they may possess. He should use them as consultants in medical problems of social and community significance.

We are now on the right track to achieve the great task remaining—the control of tuberculosis. There are vastly more effective methods of detecting and treating tuberculosis and other chest diseases than ever before. The relative roles of health educators, epidemiologists, sanatorium physicians, private practitioners is beginning to be seen quite clearly. Let no disrupting revolution in medical practice prevent this major achievement of the progressive American system of medicine.

The Present Status of Tuberculosis Control, H. Corwin Hinshaw, M.D., National Tuberculosis Association Bulletin, July, 1949.

PERSONALS AND NEWS ITEMS

R. B. Robins was recently appointed Arkansas Chairman of the World Medical Association.

R. J. Calcote announces the association with him in the practice of ophthalmology at 627 Donaghey Building, Little Rock, of his son, Robert A. Calcote.

D. A. Rhinehart, Little Rock, has been elected president of the American Registry of X-ray Technicians.

"The General Practitioner Today" by R. B. Robins, Camden, appears in the August issue of The Journal of the Florida Medical Association.

Guy Shrigley has been elected surgeon of the Clarksville post, American Legion.

Dr. and Mrs. Gordon P. Oates, Little Rock, spent a recent vacation in Colorado.

E. J. Easley, Little Rock, acted as special consultant in venereal diseases to the New Mexico Department of Health during July. Following this assignment Dr. and Mrs. Easley and family spent a vacation on the west coast.

Dr. and Mrs. J. Ken Thompson, Fort Smith, spent a recent vacation in Chicago, Omaha, Saint Louis and other midwestern points.

BORN—On August 12th, a daughter, Catherine Nell, to Dr. and Mrs. M. B. Hoqe, Fort Smith.

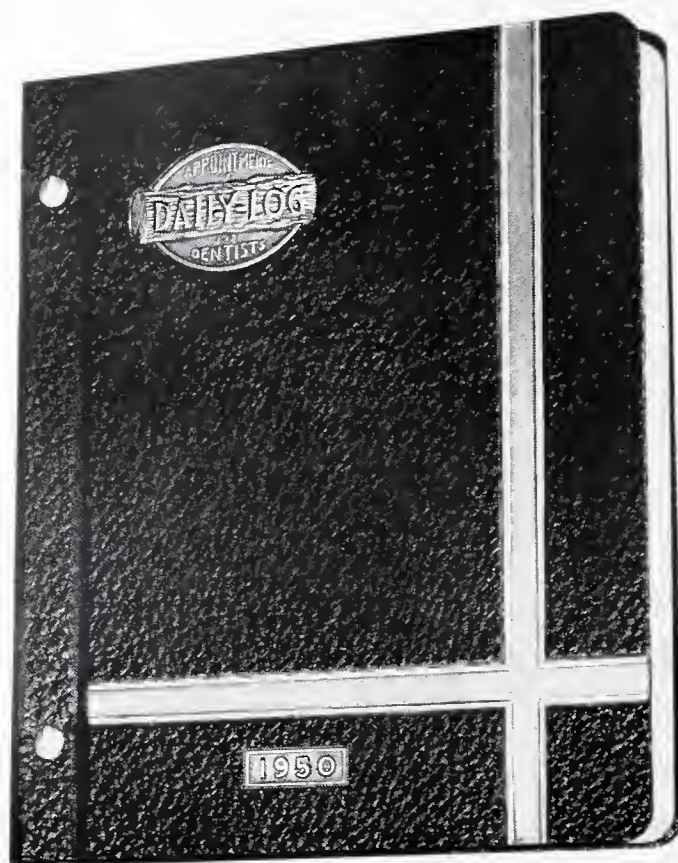
C. E. Kennedy has been elected surgeon of the Smackover post of the American Legion.

G. D. Murphy, Jr., has been elected medicin of the El Dorado Voiture, Forty and Eight.

A. S. Koenig and John D. Olson, Fort Smith, spent a recent vacation at Minnesota fishing resorts.

James S. Taylor, Chairman of the General Membership Committee of the International and Fourth American Congress, has appointed Eva F. Dodge, Little Rock, Chairman of the Arkansas Membership Committee for the Fourth American Congress on Obstetrics and Gynecology to be held in New York City on May 14-19, 1950. The following have been appointed on the Arkansas

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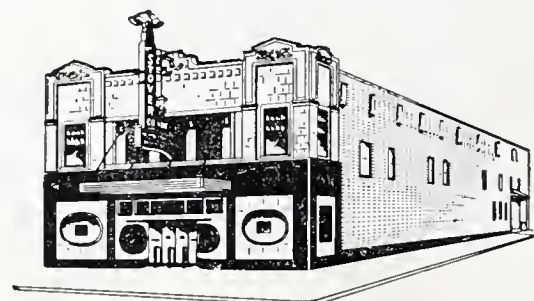
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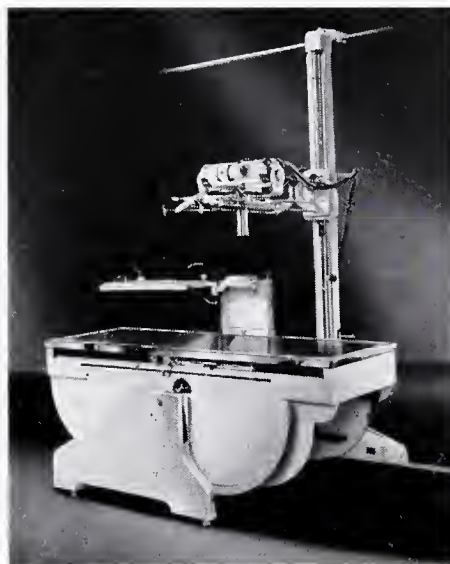
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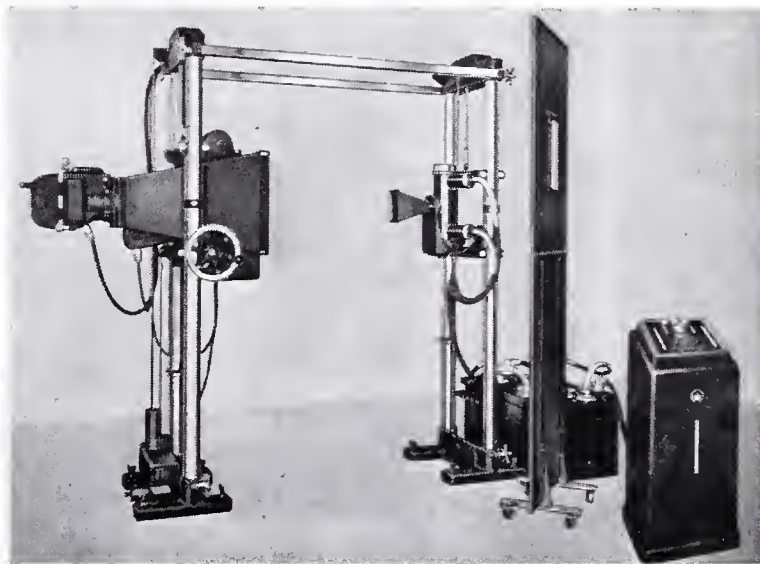
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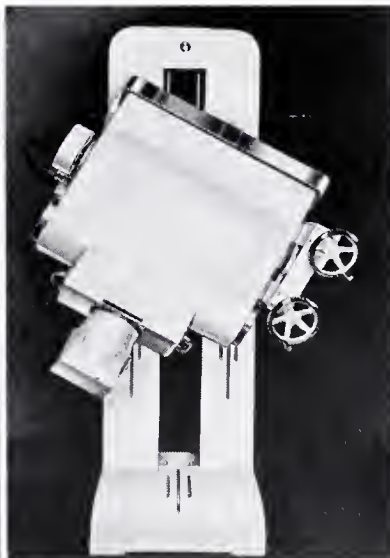
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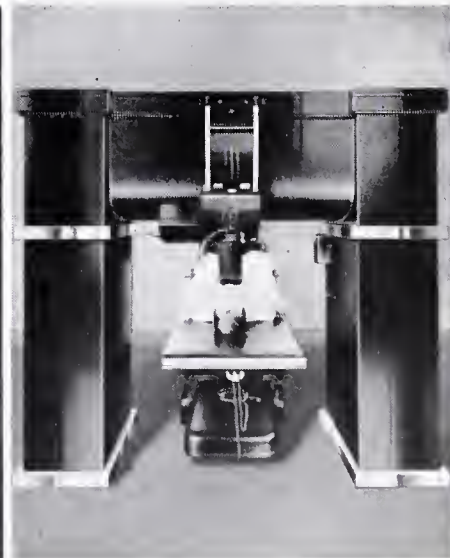
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Membership Committee: Clyde Rodgers, Little Rock; I. F. Jones, Fort Smith; Ruth E. Lesh, Fayetteville; E. T. Ellison, Texarkana; and L. E. Fitch, El Dorado.

The following have been elected surgeons of their respective American Legion posts: H. W. Thomas, Dermott; H. V. Kirby, Harrison; F. F. Ferguson, Nashville; L. D. Massey, Osceola, and Jeff Baggett, Prairie Grove.

Dr. and Mrs. J. M. Kolb, Clarksville, spent the month of July on vacation at various points in Texas, attending the Shrine convention in Chicago and at Detroit.

Robert F. Hyatt, Jr., Monticello, has been elected county chairman of the Drew County Chapter of the Arkansas Free Enterprise Association. Drew county has organized the first county chapter in the state.

B. N. Saltzman, Mountain Home, has been elected District Deputy Grand Exalted Ruler, B. P. O. E. for Arkansas.

"Serial Needle Biopsy in the Study of Hepatic Disease" by Jerome S. Levy, E. Lloyd Wilbur, George Bozalis, Robert Burger and Charles Beeson, Little Rock, appeared in the August issue of the Southern Medical Journal.

Dr. and Mrs. B. A. Rhinehart, Little Rock, spent a recent vacation in North Carolina.

"The Southwestern Surgical Congress: The Need—The Aims," an editorial by Louis P. Good, Texarkana, appeared in The Southern Surgeon, July, 1949.

Melvin R. McCaskill has opened offices for practice of gynecology and obstetrics at 711 West Capitol Avenue, Little Rock.

Dr. and Mrs. W. L. Shippey, Fort Smith, spent a July vacation in the Yellowstone, Utah and other western points.

Dr. and Mrs. J. B. Stewart, Fort Smith, spent a recent vacation in the Ozark resort area.

"A Plan to Find the Titer of An Anticomplementary Blood Serum or Spinal Fluid" by Charles E. Oates, North Little Rock, appeared in the American Journal of Medical Technology.

A. S. J. Clarke, Fort Smith, addressed the LeFlore County (Oklahoma) Medical Society at Poteau August 3rd on "Twenty Ways to Get Into Trouble with Fractures."

Charles R. Henry announced the association with him of Robert W. Ross in the practice of gynecology and obstetrics at Little Rock.

Miles F. Kelly has moved to Sheridan.

"The Doctor's Heart" and the "Memorial Address" of L. H. McDaniel, Tyronza, were published in the Congressional Record for August 15th.

PROCEEDINGS OF SOCIETIES

The Columbia County Medical Society was held August 9th by J. A. Norton, El Dorado, "Carcinoma of the Cervix" and by Geo. M. Burton, El Dorado, "Primary Carcinoma of the Skin." Charles L. Weber, Secretary.

Greene-Clay County Medical Society met at Paragould on July 20th with the following scientific program: "The Therapy of Acute Coronary Occlusions," Newton S. Stern, Memphis, and "The Ruptured Appendix," Morton J. Tendler, Memphis. Preceding the scientific program, R. L. Hutcherson, Delaplaine, was given the "50 Year Club" award at a special ceremony.

W. McD. Lamb, Secretary.

The Arkansas Society of X-ray Technicians will hold its first state meeting at the Hotel Marion, Little Rock, Saturday, November 12, 1949. The meeting will consist of a business session in the morning, a technical program in the afternoon, followed by a cocktail party and banquet in the evening, and a breakfast on Sunday morning. Several Arkansas radiologists will take part in the program. Mr. Alfred B. Greene, the registrar agent for the American Society of X-ray Technicians, will take part in the business session.

The annual Benton-Washington County Medical Society picnic was held at Lake Atalanta, Rogers, July 21st. John McDonald, Tulsa, was the guest speaker.

Crawford County Medical Society met in Van Buren July 24th for presentation of the "Fifty Year Club" award to B. L. Bennett, Van Buren. O. J. Kirksey, Secretary.

BOOK REVIEW

Clinical Auscultation of the Heart: By Samuel A. Levine, M.D., Clinical Professor of Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital; and W. Proctor Harvey, M.D., Research Fellow in Medicine, Harvard Medical School Assistant in Medicine, Peter Bent Brigham Hospital. 327 pages with 286 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$6.50.

The importance of auscultation in the diagnosis of cardiac pathology is properly emphasized in this volume. The special field is thoroughly presented. The author's insistence is that the stethoscope is a simple, economical, available method, which may suggest the need for special diagnostic studies for confirmation.

Psychosomatic Medicine—The Clinical Application of Psychopathology to General Medical Problems: By Edward Weiss, M.D., Professor of Clinical Medicine, Temple University Medical School, Philadelphia; and O. Spurgeon English, M.D., Professor of Psychiatry, Temple University Medical School, Philadelphia. New, (2nd) Edition. 803 pages. Philadelphia and London: W. B. Saunders Company, 1949. Price \$9.50.

Increasing attention is being focused upon psychosomatic diagnosis in clinical medicine and this book presents charts and tables of diagnostic findings with suggested treatment. The psychosomatic aspect of the various body systems are discussed separately.

Clinical Aspects and Treatment of Surgical Infections: By Frank Lamont Meleney, M.D., F.A.C.S., Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University; Associate Visiting Surgeon, Presbyterian Hospital, New York City. With a Foreword by Allen O. Whipple, M.D. 840 pages with 287 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$12.00.

This important work presents surgical infections prior to recent drug and antibiotic therapy and the tremendous change which these agents have brought to their management. This is a book to be studied for reference and will be of much interest to all physicians who have the responsibility of the care of infections.

Medicine Throughout Antiquity. By Benjamin Lee Gordon, M.D., Attending Ophthalmologist, Shore Memorial Hospital, Somers' Point, New Jersey. Pp. 818. 157 illustrations. Price \$6.00; Philadelphia: F. A. Davis Company, 1949.

Medicine from prehistoric times to the end of the Greco-Roman period is covered in this informative book. Much research was required in its preparation; its reading is pleasant.

Nutrition and Diet in Health and Disease. By James S. McLester, M.D., Professor of Medicine, University of Alabama, Birmingham. New, 5th Edition. 800 pages. Philadelphia and London: W. B. Saunders Company, 1949. Price \$9.00.

Physicians will welcome this new revision of an old classic. The book gives not only the basic knowledge of nutrition, but applies this knowledge to practical dietetics. The author has brought together the best present-day viewpoints on the relation between diet and disease, and has presented them in a simple and usable manner. It is evident that the author believes that not only disease of nutritional origin should be treated by diet, but that dietary management should be an important part of the treatment of all medical and surgical conditions. In any

work of this magnitude some errors are inevitable, and this book has its share. Some of these, as the statement that beef fat is the basis of oleomargarine (page 221), result from failure of revise the text to conform to present day practices. Others, as the incorrect structural formula for folic acid (page 79), obviously result from failure to check new additions to the text against original sources. The volume is bound in durable cloth, but the quality of printing is below the standard expected of a book with the Saunders imprint. In spite of these minor shortcomings the book should be on the highly recommended list.

You and Your Doctor. A Frank Discussion of Group Medical Practice and Other Modern Trends in American Medicine. By Benjamin F. Miller, M.D., Clinical Professor of Medicine, George Washington Medical School, Etc. Pp. 183. Price \$2.75. New York: Whittlesey House, McGraw-Hill Book Company, Inc., 1948.

The advantages proclaimed for group practice are presented to the public in this volume and emphasis is placed on the allegedly proper role of the general practitioner—"pilot physician to the specialist." Group medicine is well presented in this book but few physicians will agree with the author's prescription for the cure of medical care ills—compulsory health insurance. The author's disagreement with the great majority of the profession is perhaps the reason for the book.

Your Baby, the Complete Baby Book for Mothers and Fathers. By Gladys Denny Schultz, Contributing Editor, The Ladies Home Journal, and Lee Forrest Hill, M.D. Price \$3.50; Garden City, New York; Doubleday and Company, 1948.

This book supplements proper medical advice to the new parents and is well-written. The latest approved ideas on child care and related problems together with pages to record baby's growth and development combine in a complete baby guide.

Essentials of Pathology. By Lawrence W. Smith, M. D., Associate Professor of Pathology, Cornell University Medical School, Etc., and Edwin S. Gault, M.D., Associate Professor of Pathology and Bacteriology, Temple University School of Medicine. Third edition. Pp. 764 with 740 illustrations. Philadelphia: The Blakiston Company, 1948. Price \$12.00.

This is a well-arranged text with material organized, numerous photographs and illustrative case histories. Descriptions are brief yet comprehensive.

Handbook of Orthopedic Surgery. By Alfred Rives Shands, Jr., M.D., Medical Director of the Alfred I. DuPont Institute of the Nemours Foundation, Etc., in collaboration with Richard Beverly Raney, M.D., Associate in Orthopedic Surgery, Duke University School of Medicine. Third edition. Price \$6.00. Saint Louis: The C. V. Mosby Company, 1948.

This is a widely-accepted text which covers the entire field of orthopedic surgery in concise, clear and well-organized manner.

Preoperative and Postoperative Care of Surgical Patients. By Hugh C. Ilgenfritz, M.D., formerly Assistant Professor of Surgery, Louisiana State University School of Medicine. Pp. 898. Illustrated. Price \$10.00. Saint Louis: The C. V. Mosby Company, 1948.

The author has carefully described the physiologic approach in the care of the surgical patient and the book is recommended especially for interns and residents although the general surgeon will find it of much value.

Aesculapius Comes to the Colonies. The Story of the Early Days of Medicine in the Thirteen Original Colonies. By Maurice Bear Gordon, M.D. Pp. 560. Price \$10.00. Ventor City, New Jersey: Ventor Publishers, 1949.

The author has carefully studied the medical history of the thirteen original colonies and has written a thrilling account of the activities and influence of the physician in our colonial times.

Oral and Dental Diagnosis. With suggestions for Treatment: By Kurt H. Thoma, D.M.D., F.D.S.R.C.S. Eng., Professor of Oral Surgery, Emeritus, and Brackett Professor of Oral Pathology, Harvard University. With Contributions by Henry Goldman, D.M.D., Head of the Dental Department, Beth Israel Hospital, Boston; Fred Trevor, D.M.D., Formerly Instructor in Oral Pathology, Harvard Dental School. New, 3rd edition. 563 pages with 776 illustrations, 60 in color. Philadelphia and London: W. B. Saunders Company, 1949. Price \$9.50.

Oral and Dental Diagnosis by Dr. Kurt H. Thoma is the most complete text on oral diagnosis I have encountered. Diseases and malformations, both simple and most complex, are treated in Thoma's usual complete and thorough manner. In addition to its material on diagnosis, it has suggested treatments, both local and systemic. Oral and Dental Diagnosis is in the same class with Thoma's excellent books on Oral Pathology, and Oral Surgery.

This is a very easy reading text which should be in every dental library.

The Business Side of Medical Practice: By Theodore Wiprud, Executive Director and Secretary of the Medical Society of The District of Columbia and Managing Editor of the Medical Annals of the District of Columbia. Second Edition. 232 pages with 22 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$3.50.

This volume covers all of the phases of medical practice; records, investments, insurance, public speaking, testimony in court, community and medical leadership, medical writing and all. The value of this book to all practitioners, especially to the young man entering into his own practice, can not be overemphasized. The author writes from an active association with physicians of over fifteen years, an association which has brought to the medical societies he has served efficiency, initiative and enthusiasm in organization activity.

WOMAN'S AUXILIARY NEWS

The 9th Councilor District Auxiliary met June 17th at the Hotel Seville in Harrison for a dinner meeting with the doctors. Dr. Euclid Smith, of Hot Springs, President of the Arkansas Medical Society, gave the address. After dinner a short business meeting was held by the Auxiliary. A motion to amend our Constitution and By-Laws to take care of increase in State and National Auxiliary dues was made by Mrs. H. V. Kirby. The motion carried. Mrs. J. H. Fowler gave a report of Doctors' Day. Mrs. J. G. Gladden reported on Medical Legislation and what our

Auxiliary is doing. Mrs. Ulys Jackson read a letter from the Honorable Jim Trimble to the Auxiliary pertaining to the medical bills now in Congress. The following members were present: Mesdames Mrs. A. V. Adams, W. A. Bradley, W. H. Breit, A. L. Carter, J. H. Fowler, R. E. Fowler, J. G. Gladden, Ulys Jackson, H. V. Kirby, D. L. Owens, A. F. Stanley, and B. N. Saltzman. The next meeting will be held in December.

Mrs. Ulys Jackson, Secretary.

Mrs. Lina E. Stroud, wife of Dr. H. A. Stroud, Jonesboro, passed away recently at her home in Jonesboro following a brief illness. Mrs. Stroud was an active member of the Craighead-Poinsett County Auxiliary.

The Woman's Auxiliary to the Craighead-Poinsett County Medical Society met on August 4, 1949, with the doctors for the Annual Barbecue at the Jonesboro Country Club. Dean F. T. Roberts of the University of Tennessee School of Medicine was guest speaker and the ladies enjoyed his most enlightening and entertaining talk on legislation.

Mrs. Malcolm O. Peeler, Secretary.

FALL CLINICAL CONFERENCE

The Kansas City Southwest Clinical Society will present the 27th Annual Fall Clinical Conference October 3, 4, 5, 6. Four days of scientific presentations . . . clinicopathologic conference . . . citizen-physician problem . . . daily round table luncheons with question and answer period . . . scientific and technical exhibits . . . movies . . . entertainment . . . headlined by the following:

Edgar V. Allen (M), Rochester; Harry E. Bacon (PR), Philadelphia; Grayson L. Carroll (U), St. Louis; O. T. Clagett (S), Rochester; R. W. Danielson (Oph), Denver; Aubrey Hampton (R), Washington; Lewis M. Hurxthal (M), Boston; Frank H. Lahey (S), Boston; Virgil H. Moon (Path), Winston-Salem; Walter L. Palmer (M), Chicago; John L. Parks (OG), Washington; I. S. Ravdin (S), Philadelphia; Wolf. W. Zuelzer (Pd), Detroit.

A program you cannot afford to miss. Check your July-August, 1949, Kansas City Medical Journal for details or write the Executive Office, 630 Shukert Building, Kansas City 6, Missouri, for a copy.

OCT 12 1949

San Francisco, 22

The JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

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No. 5

THE PATHOGENESIS, DIAGNOSIS, AND MANAGEMENT OF ACUTE POLIOMYELITIS *

EDWARD S. MILLER, M. D.
Denver, Colorado

"The diagnosis and treatment of poliomyelitis" is the announced title of this presentation. Significant advances have been made in recent years in our understanding of the epidemiology and pathogenesis of this disease. Therefore, I should like to expand the scope of this paper to comment on some of these problems. On the other hand I shall restrict my remarks to a discussion of the **acute** phase of poliomyelitis only.

Etiology: The agent which causes human poliomyelitis is one of the smallest of the filtrable viruses. Recent studies have shown that there are a number of diverse strains which differ in their antigenic properties, and possibly also in their virulence. The existence of multiple strains is a matter of fundamental importance, for it may mean that recovery from infection with one variety of virus is not necessarily followed by immunity to infection with other strains.

This infectious agent is unusually resistant to destruction. It can survive in water and sewage for as long as four months. It may not be killed by chlorine in the amounts ordinarily used for the purification of water supplies.

Man is the only natural host, and consequently, the only reservoir of infection. By the same token, each new case must derive directly or indirectly from some other human case or carrier. The disease can be transmitted experimentally to monkeys and chimpanzees, and a few strains have been adapted to rodents. However, primates continue to be the most suitable animals for research purposes, a fact which has rendered the study of poliomyelitis particularly difficult and expensive.

Pathogenesis: In our examination of the natu-

ral history of this disease, we are concerned first with the passage of the virus through the body of an individual, and second with its spread through a large group of individuals.

It was once generally believed that poliomyelitis virus invaded the body by way of the olfactory nerves. However, accumulating evidence has shown that this is not usually the case. The oropharynx is the most important portal of entry, via the mouth, and less commonly the nose. The virus then passes down into the gastrointestinal tract and presumably multiplies there. The agent can be found along the entire length of the alimentary canal, within the substance of the mucosal wall itself.

The next step in the pathogenesis of infection consists of the invasion of the nervous system. Virus particles in some unexplained manner enter adjacent nerve endings in the alimentary tract, travel centripetally along axones, and thus are carried to the cord or the brainstem. Virus then spreads centrifugally throughout the central nervous system, attacking the most susceptible cells, namely the motor neurons. The principal lesions are usually seen in the anterior horn cells of the cord, but lesions may also be found in various parts of the brain.

Most infected individuals show no symptoms whatsoever, or else general symptoms so mild as to be disregarded. However, a certain few patients manifest clinical evidence of invasion of the central nervous system, with development of a characteristic paralytic encephalo-myelitis. These are the cases which we recognize clinically as poliomyelitis.

The infected individual, whether or not he is clinically ill, excretes large quantities of virus in his stools over a period of several weeks to several months. A healthy carrier is therefore quite as dangerous to the community as a patient with full blown poliomyelitis. During an epidemic the virus can be recovered from the feces of a significant proportion of the population, as well as from the raw sewage of affected communities. Virus can also be found in the pharyngeal dis-

* Read before the Seventy-third Annual Session, Arkansas Medical Society, Little Rock, April 15, 1949.

charges of some patients, and may be broadcast into the atmosphere by coughing or by spitting.

Thus we have developed the concept of poliomyelitis as an epidemic disease which periodically infects large numbers of individuals in a region. Most of the cases are subclinical; out of each 100 infected, perhaps only one will become paralyzed. We still know little about the forces which determine the selection of this unfortunate individual. However, there are several predisposing factors of which we are aware. It is well established that tonsillectomies and other operations in the mouth or pharynx, if performed during the season of epidemic prevalence, greatly increase the risk of developing bulbar poliomyelitis. Furthermore, animal experiments indicate that physical exhaustion or chilling during the period of incubation results in an increase in the incidence and extent of paralysis.

Epidemiology: Having explored the passage of the virus through the individual patient, we are next concerned with the mode of spread of the disease in a population. The organism passes directly or indirectly from one patient to another, either via feces, or via nasopharyngeal secretions. The weight of present evidence indicates that dissemination by feces is the more important of the two. It seems likely that this transmission may be accomplished in a number of ways. Close contact appears to be important in the spread of the disease. It is possible, though yet to be established, that contaminated water, milk or food play a significant role in transmission. Considerable interest has centered recently on the possibility that flies may convey the organisms from feces to food.

Poliomyelitis shows a striking seasonal incidence. In the northern hemisphere most cases are seen during the months of July, August, September and October. In the southern hemisphere, where the seasons are reversed, the infantile paralysis season is likewise reversed. These facts support the hypothesis that fecal spread of the diseases is important, for it is well known that other infections transmitted by feces are most numerous in the summer and fall, whereas diseases spread by the respiratory tract are more common during the winter and spring.

A discussion of epidemiology would not be complete without mentioning the remarkable change in the character of the illness during the past 70 years. Previous to that time poliomyelitis was a rather rare, sporadic disease which affected almost exclusively children under the age

of five; hence the name **infantile paralysis**. However, since 1870 the infection has appeared in epidemics in certain parts of the world, notably in Scandinavia, the United States, Canada, Australia, and Great Britain. In these countries there has been a gradual but definite increase in the average age of the patients. In some recent U. S. outbreaks, as few as one-third of the victims were less than five years of age, while another third were more than fifteen years old. In other parts of the world poliomyelitis continues to be sporadic and continues to affect chiefly young children.

Clinical: Clinically, poliomyelitis assumes any of four different forms, which are designated by the names **subclinical**, **abortive**, **preparalytic**, and **paralytic**. The large preponderance of infections are symptomless, and hence are referred to as **subclinical**. In the other cases, illness begins with nonspecific constitutional symptoms of fever up to 103° F., headache, myalgia, drowsiness, anorexia, and sometimes nausea and vomiting. Contrary to popular belief, rhinitis, cough, and diarrhea are not symptoms of poliomyelitis. The initial phase of illness lasts for one to three days, after which the patient may make an uneventful recovery; this syndrome is designated as **abortive poliomyelitis**. In other instances, the phase of onset is followed immediately or after a short remission by signs of central nervous system irritation. Patients exhibit stiffness, soreness, and spasm of the muscles of the neck, back, and legs. Sore throat is also a common complaint. This stage is referred to as **preparalytic poliomyelitis**. A proportion of patients recover even from this stage without developing muscular weakness. However, in the majority of cases the **paralytic phase** of disease ensues within one to four days.

It is customary to classify paralytic cases into two types according to the clinical distribution of neurologic lesions. The **spinal type** refers to patients in whom paralysis is limited to muscles innervated from the cord. The **bulbar type** includes patients who have signs referable to lesions of the brain. These types may, of course, coexist.

The physical findings in a typical case of acute poliomyelitis are characteristic. The fever is usually not greater than 103° F. The patient is irritable, often somnolent, but usually mentally clear when aroused. The neck is stiff and Kernig's sign can be elicited. Various muscles exhibit involuntary spasm and a sensitivity which is aggravated by motion or by palpation. Paralysis

depends on injury to individual motor cells, and therefore is patchy, asymmetrical, and does not coincide with the distribution of peripheral nerves. A group of muscles, a single muscle, or only a portion of a muscle may be affected. It is a flaccid lower motor neuron type of paralysis, with absent deep tendon reflexes. The lower limbs are most frequently involved. In the upper limbs the shoulder girdles tend to be more severely affected than the distal portions of the extremities. Lesions of the cervical and thoracic segments of the cord result in paralysis of the diaphragm and intercostal muscles, leading to serious and sometimes fatal respiratory embarrassment. There are no sensory disturbances in poliomyelitis other than tenderness of muscles—a fact of great importance in differential diagnosis.

Signs of brain involvement may appear at any time in the course of the acute phase of illness.

The Minnesota Poliomyelitis Research Commission offers the following useful classification:

CLASSIFICATION OF BULBAR POLIOMYELITIS:

1. Cranial nerve nuclei group:

- a. Upper cranial nerve group: III, IV, V, VI, VII, VIII.
- b. Lower cranial nerve group: IX, X, XI, XII.

2. Central autonomic group:

- a. Respiratory center.
- b. Circulatory center.

3. Encephalitic group:

- a. Diffuse.
- b. Focal.

4. Combined bulbar-cervicothoracic group:

Acute poliomyelitis runs a self-limited course lasting three to seven days. Paralytic phenomena may appear at any time during this period, but progression of neurologic damage ceases with the subsidence of fever. However, spasm and tenderness may persist for some weeks.

These, then, are some of the clinical characteristics of infantile paralysis. The physician must make his diagnosis chiefly on the basis of clinical findings, for unfortunately there is as yet no convenient laboratory test for specific diagnosis.

Laboratory diagnosis: The only laboratory procedure of practical value in diagnosis consists of an examination of the cerebrospinal fluid. Abnormalities are found in 90 per cent or more of cases of paralytic poliomyelitis; while these changes are not pathognomonic, they are characteristic, so that lumbar puncture should be performed in all suspected cases. The white blood

cell count of the fluid is increased, reaching a maximum of 10 to 500 during the first week of illness; rarely the count may rise higher than 1000. The cells are predominantly lymphocytes, though occasionally as many as 50 per cent will be polymorphonuclear leucocytes. The spinal fluid protein is commonly elevated to levels of 60 to 125 mg. per 100 cc. during the first few weeks. The leucocyte count of the blood is normal or slightly elevated. The blood sedimentation rate is usually normal.

The etiologic agent can be isolated from the stools of patients or of carriers, by inoculation into monkeys. However, this procedure is difficult and expensive, and therefore is used only in special research problems.

Treatment: There is no specific method of treatment of poliomyelitis. The available therapeutic measures are all symptomatic and supportive in nature. They are aimed at saving life, relieving symptoms, preventing deformity, and salvaging and developing to the full what is left after the acute illness has run its course.

The patient is kept at strict bed rest, and all physical activity is discouraged. Unnecessary and exhausting manipulations are to be avoided, and detailed evaluation of muscle function should be postponed until the acute illness has subsided. Patients are frightened, and in need of constant reassurance. The affected parts are placed in positions of greatest comfort and immobilized in such a way as to prevent deformities. The local application of heat often affords temporary relief of muscular spasm, pain, and tenderness. This can be administered by periodic applications of hot moist compresses.

There is no proven chemotherapeutic agent which influences the poliomyelitic process itself. Aspirin may be used for its analgesic effect. Some patients, especially adolescent boys, suffer from transient urinary retention. This can usually be relieved, and catheterization avoided, by using a parasympathomimetic drug called "Furmethide." Patients with disturbances in breathing and swallowing are in danger of developing pneumonia, and should be given penicillin prophylactically. It is important to avoid such drugs as codeine, morphine, and barbiturates, for they may precipitate respiratory failure. Neostigmine and curare have been recommended for relief of muscle spasm, but I do not advocate their use until more is known about their efficacy and safety.

The management of bulbar cases is especially difficult and especially important because nearly

all deaths in acute poliomyelitis occur in this group of patients. Lack of oxygen constitutes an immediate threat to life in most of these individuals. Hypoxia may result from pooling of pharyngeal secretions, obstruction of the airway, irregularities in rate or depth of respiration, or pulmonary edema. Secretions must be removed by postural drainage and by suction. Oxygen is administered by nasal catheter. Recently it has been shown that tracheotomy is a useful procedure in selected cases, especially in the presence of paralysis of the ninth, tenth, and twelfth cranial nerves.

The mechanical respirator has proved to be a life-saving measure in patients with cervico-thoracic cord involvement and paralysis of the respiratory muscles. Such patients should also receive oxygen through a nasal catheter. It is sometimes necessary to use the respirator for patients with paralysis of the respiratory center, if they are unable to maintain an adequate exchange of air. However, its use under these circumstances is difficult and dangerous, and requires experienced judgment.

Oral feeding is dangerous in the presence of pharyngeal paralysis, and one must rely on intravenous alimentation, followed later by gavage.

Therapy beyond the acute stage of poliomyelitis includes passive, and then active motion of affected muscles. It involves muscle re-education, proper braces, and sometimes operative correction of deformities. These measures require the special skills of experts in physical medicine and in orthopedic surgery, and are outside the scope of this report.

Prevention: Despite great efforts devoted to the development of an immunizing agent, there is yet no vaccine which will prevent the disease in man. I have already mentioned a few predisposing factors; attention to these will perhaps protect a few individuals. Tonsillectomy operations should not be performed during seasons of prevalence. Undue physical exhaustion and chilling are likewise to be avoided.

Summary: Poliomyelitis occurs in seasonal outbreaks in the United States. At such times a large number of people are infected, and a small fraction of these develop the paralytic form of the disease. Evidence points to the alimentary tract as the chief portal of entry and of egress of the virus. Diagnosis is based on the clinical findings and the spinal fluid changes. There is as yet no practical laboratory test for specific diagnosis. Treatment of the acute phase of disease is symptomatic and supportive in nature.

STATEMENT OF R. B. ROBINS, M. D.

DEMOCRATIC COMMITTEEMAN FOR ARKANSAS
AT MEETING OF

DEMOCRATIC NATIONAL COMMITTEE,
WASHINGTON, AUGUST 24, 1949.

I desire to bring to the attention of the Committee at this time a dangerous threat to the strength and unity of the Democratic Party.

I refer to the misuse of the good offices of this Committee in support of agitation for Compulsory Health Insurance. Such agitation, emanating from offices as high as that of our Chairman, threatens to "read out" of the Democratic Party many hundreds of thousands of persons who are now on record as opposing Government control of medicine.

I submit that this agitation by members of the Committee is reckless and unauthorized. The Democratic Party is not on record in its Party Platform as favoring Compulsory Health Insurance. At the Philadelphia Convention last year the Democratic Party announced support of a National health program for expanded medical research medical education and hospital and clinic facilities. This does not constitute endorsement or recommendation of Compulsory Health Insurance.

The Compulsory Health Insurance issue is a bad penny that turns up every few years. It has never obtained sufficient support to merit incorporation in the platforms of either of the major political Parties. It has never obtained sufficient support to be legislated in Congress. The reasons for this weakness is apparent. In every large Nation where Government medicine has been attempted, there has been a decline in the quality and quantity of medical services and an increase in their cost. Only borrowed American dollars prevent its utter disintegration in these same countries today.

Admittedly, some way must be found to take the financial shock out of illness. Voluntary Health Plans are one answer. The proof of this is in the rapid growth of these plans. More than 60 million Americans are now insured against the expense of major illness through these plans. They are not yet perfect, but they are being improved all the time, both as to range of coverage and benefits.

I have no intention of taking up the time of this Committee discussing in detail the question of Voluntary versus Compulsory Health Insurance. There is a wealth of factual material, including a study by the impartial Brookings Institution, in support of the argument that the

voluntary way is the best way to meet the need for budget-basis medical care.

Not only are hundreds of thousands of physicians and dentists opposed to Government controlled medicine, but there are more than fifteen hundred civic, service, veteran and other organizations with memberships totaling millions that have gone on record against it.

The time has come to ask ourselves some very serious questions.

Ladies and Gentlemen, do we want to serve notice on the five million members of the General Federation of Women's Clubs that they are not wanted by this Party because they have gone on record against socialized medicine?

Can we afford to tell members of such organizations as American Farm Bureau Federation, The National Grange, and the American Legion that there is no place for them in the Democratic Party because they oppose Compulsory Health Insurance?

Are the loyal Americans who constitute almost the total membership of the Chambers of Commerce in this country unwelcome because they too have gone on record as against Compulsory Health Insurance?

I could continue almost indefinitely reading the roster of some of the finest, most patriotic, non-political organizations in the United States which are on record against socialized medicine. There is hardly one of these groups whose support would not be a credit and comfort to our Party in the coming elections.

Frankly, ladies and gentlemen, I am sometimes hard-put to defend our Party against the assertions of my doctor friends and others who are convinced that the Democrats are against the medical professions. Yet I am not speaking as a doctor or even from the standpoint of the Southern States.

The opposition to Compulsory Health Insurance transcends every geographical, economic and political boundary in this country. This is well proved by the roll call of the Senate last week against a Reorganization Plan which would have placed Oscar Ewing in a Cabinet Post.

Ladies and gentlemen, this was a vote against socialized medicine. It was also a vote of no confidence in socialized medicine's leading exponent, Oscar Ewing. This is obvious when you realize that twenty-three of our Democratic Senators joined that vote despite a personal plea from the President to support the Reorganization Plan. Other Reorganization Plans having nothing

to do with Mr. Ewing were passed by the Senate and favored by many Republicans.

It is easy to perceive the beginnings of a significant rift in our Party. I ask you to consider how history is strewn with the hulks of political Parties which have foundered on the shoals of unpopular issues.

I will grant you that we have had division and secession in our Party before. We have had our splinter Parties. However, it would be a grave mistake to underestimate the division that is shaping up today in our ranks—a division not of regional or economic interests, but one of socialism versus Americanism. The plain fact is that we are now in grave danger of making an error which may cost us our leadership in National Government.

In Compulsory Health Insurance we are creating a Frankenstein that will, I predict, drive out of this great Party a great number of loyal Americans.

Compulsory Health Insurance is repugnant to the ideals and convictions of the American People. It is unworthy of the tradition of a Party which has always put the peoples' interests first. This is an historical juncture in the history of our Party. We have long prided ourselves on our ability to hear the voice of the people. If we do not hear it now, we may never have an opportunity to respond to it in the future.

SOUTHEAST ARKANSAS MEDICAL AUXILIARY

The Southeast Arkansas Medical Auxiliary met Monday night, August 15th, at Lake Village at the Country Club. After dinner with the doctors, the ladies went to the social room for their meeting. Mrs. Burge of Lake Village, President-Elect, presided in the absence of the President. Letters of acknowledgment were received and read for the resolutions sent in by the Auxiliary from President Truman, Senator McClellan, Senator Fulbright, Representative W. F. Norrell and Representative Oren Harris. Also acknowledgments were received and read from Whitaker and Baxter.

A letter was read from Mrs. Gordon Oates of Little Rock suggesting that material be passed out at County Fairs on Socialized Medicine.

After a short business meeting, a social hour was enjoyed playing Bingo.

Mrs. Van C. Binns,
Publicity Chairman.

THE JOURNAL

OF THE

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EDITORIAL

H. CLAY CHENAULT : AN APPRECIATION

Over the past three years activity at the University of Arkansas School of Medicine has been intensified over the normal course of events there. Faced with internal difficulties, with probable loss of its Class "A" rating, inadequate teaching facilities, pressure for admissions, loss of revenue, a shortage of personnel and insufficient revenue, the situation was one of pessimism. At this time the Board of Trustees appointed H. Clay Chenault as the principal administrative officer of the school, first as the dean, and later as vice-president in charge of hospitals and medical education.

It is not yet possible to say that the manifold difficulties of the medical school have been removed and the future of expanded medical education in Arkansas is one of optimism, yet one can record that there has been a real awakening to the value and need of adequate medical education in Arkansas. Appropriations have been made to start a proper building program, the teaching facilities have been improved,

faculty prestige and morale are at a high level, revenues have been increased and the influence of the school has been extended in the state. It is now possible to look ahead with some hope to the eventual rise of a medical school of which the state may well be proud.

These have been attained and accomplished by diligence and enthusiasm of all those who realize the value of medical education but to H. Clay Chenault the accomplishment is in the nature of a personal victory.

He has done the job well.

EDITORIAL COMMENT

50-YEAR PINS

The Society has directed that 50-Year pins be awarded in the future by the respective county medical societies in order that full local recognition and publicity might be given the recipient. County medical societies are asked to make request for pins to be so awarded as their members attain this seniority in practice. Opportunity will thus be afforded to present this award at a suitable local ceremony when friends, colleagues and the public may participate. Plans are under way for the 50-Year Club to meet during the 1950 annual session in Fort Smith and due notice will be given of this meeting.

1950 MEMBERSHIP ASSESSMENT

Members and county society secretaries are reminded that the House of Delegates at the 1949 annual session unanimously placed the 1950 annual membership assessment at twenty dollars. The increasing activities of the Society require additional funds. The members of the House of Delegates wisely agreed that funds as are needed should be made available for the work of the Society in 1950. Members will favor the Society and the county secretaries by early payment of the assessment.

THE 1950 ANNUAL SESSION

The 1950 annual session of the Society will be held at the Goldman Hotel, Fort Smith, Monday, Tuesday and Wednesday, April 17, 18 and 19. Members wishing to present papers before the Scientific Session should communicate with Dr. H. King Wade, Jr., Wade Clinic, Hot Springs National Park, Chairman, Committee on Scientific Program. The desirability of early hotel reservations is suggested.

RANDOM THOUGHTS OF THE SECRETARY

August 28th. With the Oklahoma State Radiological Society at Greenberger's villa in McAlester today; the utmost in gracious hospitality, the pleasure of association with colleagues, the unusual in roentgenograms and the great joy of motoring somewhere with Peggy, as we seldom do, brings to a close another of the happy days that have been our lot.

September 1st. We wonder why Bill Stover could not think of the many good reasons why we should have been picked to make that study of English medical practice.

September 3rd. Tonight joining in the festive mood of the Kappa Sigmas at Fayetteville.

September 7th. Health hint to a governor: You cannot eat at barbecues all summer without making headlines with your stomach ache.

September 12th. To staff meeting where a harassed architect endeavors to explain the new hospital plans, with our contribution being comments as to the luxury of installation of air-conditioning for surgeons, and thence to Goldstein's party for Louis Byars, the-home-town-boy-who-made-good-in-the-city and now visits us for the day.

September 13th. President Loyce Hathcock and Secretary Koenig present a top-notch scientific program for the assembled Tenth Councilor District meeting and in the evening to a gay banquet session, enlivened for all others present by Louis Byars who discusses the great advantages of surgery over irradiation in the treatment of malignancy.

ARKANSAS ACADEMY OF GENERAL PRACTICE

The Arkansas Academy of General Practice will hold a meeting Friday, October 14th, at the Albert Pike Hotel, Little Rock. The session will begin at 9:00 A.M. and luncheon will be served at a cost of \$1.50. Registration fee for non-members of the Arkansas Academy of General Practice will be \$2.

The following program will be presented: "The Practical Solution of Some Common AnoRectal Problems," Marion S. Craig, Jr., Little Rock.

"Present Day Status of Diabetes," Hal Dildy, Little Rock.

"Some Common Problems in Otolaryngology," Fred Ogden, Fayetteville.

"Cancer of the Oral Cavity," Carl A. Rosenbaum, Little Rock.

"Management of Leucorrhea," Eva Dodge, Little Rock.

"Practical Considerations in Traumatic Amputations," Paul Hoover, Little Rock.

"Recent Advancements in Blood Dyscrasias

with Review of New Drugs," Benjamin Wells, Little Rock.

"Common Errors in Fracture Reduction," Jos. F. Shuffield, Little Rock.

"Manikin Demonstration of Obstetrical Forceps," Willis E. Brown, Little Rock.

"Evaluation of Eye Problems in Children," James L. Smith, Little Rock.

ESSAY CONTEST

MRS. W. J. HUNT, Chairman, Warren

The Auxiliary, at the request of the Arkansas Medical Society, is sponsoring an essay contest in the senior high schools of Arkansas during the school year 1949-1950.

A recent poll of high school students taken by the Purdue University revealed some facts that should certainly arouse our interest and concern over the trends in the thinking of our students.

About 10,000 high school students were asked the question: "Should or should not our government establish a permanent system of providing medical services for all?" The results were as follows (October, 1948):

Should	Should Not	Undecided
80%	11%	9%

The "Shoulds" increased 3% over a similar poll made in 1944.

This growing tendency on the part of students to support socialized medicine is obviously a result of the Administration's propaganda for government controlled medical care.

Unless we educate our pupils on the value of private practice, in a few years the vast majority of young voters will be made up of advocates of socialized medicine.

The contest should have the support of every county medical society as well as every auxiliary.

Our schools' curricula are crowded and they have a tendency to ignore the many appeals which come to them to conduct essay contests. If the medical profession will show its interest and encourage the principals to cooperate, there will be much more response from them. It is very essential that we do our best to see that every senior high school in Arkansas participates in the contest.

DOCTOR ... at Stover's

The ISOLETTE

An incubator and isolation unit designed for the hospital care of infants — based upon original principles established at Children's Hospital of Philadelphia.

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The ISOLETTE permits a selection of the proper temperature required to keep the body temperature of the infant at normal, and maintains control at that level automatically. Temperature variations over the mattress area are limited to a range of 5°F and the indicating thermometer correctly reflects this range. Fluctuations of temperatures are limited to $\pm 1\frac{1}{2}$ °F by the automatic thermostatic control.

COOLING

A built-in ice chamber is capable of reducing the temperature in the ISOLETTE 20-25° from a room temperature of 105° or can be used at any time when the room temperature exceeds that desired for the infant. This feature makes the ISOLETTE suitable for use in excessively hot weather and in tropical climates. Setting of the automatic thermostat prevents over-cooling.

OXYGEN CONCENTRATIONS

Maximal concentrations can be maintained with a minimal flow, resulting in substantial savings in operating costs. For example, at an oxygen flow of 2 liters per minute a concentration of 40% can be maintained. Concentrations as high as 70-75% can be reached and maintained.

HUMIDITY

The relative humidity within the ISOLETTE may be controlled at any desired level from that of the surrounding atmosphere to 95%.

CONSTANT ATMOSPHERIC ENVIRONMENT

As the ISOLETTE remains closed while the infant is being fed, weighed, or otherwise cared for, prescribed temperature, humidity, and oxygen concentrations are undisturbed.

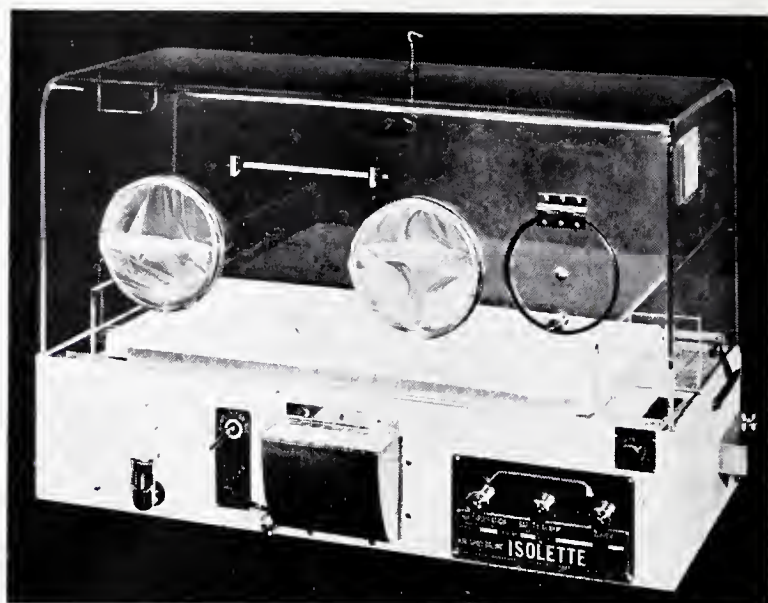
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Infants are not clothed and bedding is reduced to a pad or its equivalent, thereby affording complete freedom of muscular activity and eliminating unnecessary handling. The ISOLETTE'S large mattress dimensions (26" x 14½") recommend its use with full term infants (up to the age of 6 months).

EXCELLENT VISIBILITY

The complete visibility through the transparent hood permits observation of the unclothed infants from any point in the nursery. Changes in color or in respiratory rates are readily apparent.

EACH ISOLETTE BEARS A ONE YEAR GUARANTEE FROM DATE OF PURCHASE



WEIGHING

Infants can be weighed within the ISOLETTE without opening PLEXIGLAS hood (see illustration), or changing the atmospheric conditions within the unit. Only one set of scales is required for an installation of any number of ISOLETES.

NURSING & ISOLATION TECHNIQUES SIMPLIFIED

In a nursery completely equipped with ISOLETES doctors and nurses may work under comfortable atmospheric conditions without caps, gowns, or masks. Installations permit care of normal, anoxic, and surgical patients, as well as different infectious cases in the same ward.

SPECIAL SAFETY FEATURES

A loud buzzer and a red light actuated at 102 degrees by a fixed point thermostat indicate overheating from any cause and the heater is automatically turned off.

All electrical equipment is contained in a separate ventilated compartment readily accessible for maintenance and repair.

Six safety ventilation holes in the hood provide adequate ingress and egress of air by convection in the event of power failure.

Operating instructions are sealed between plastic sheets with means for hanging at any convenient location.

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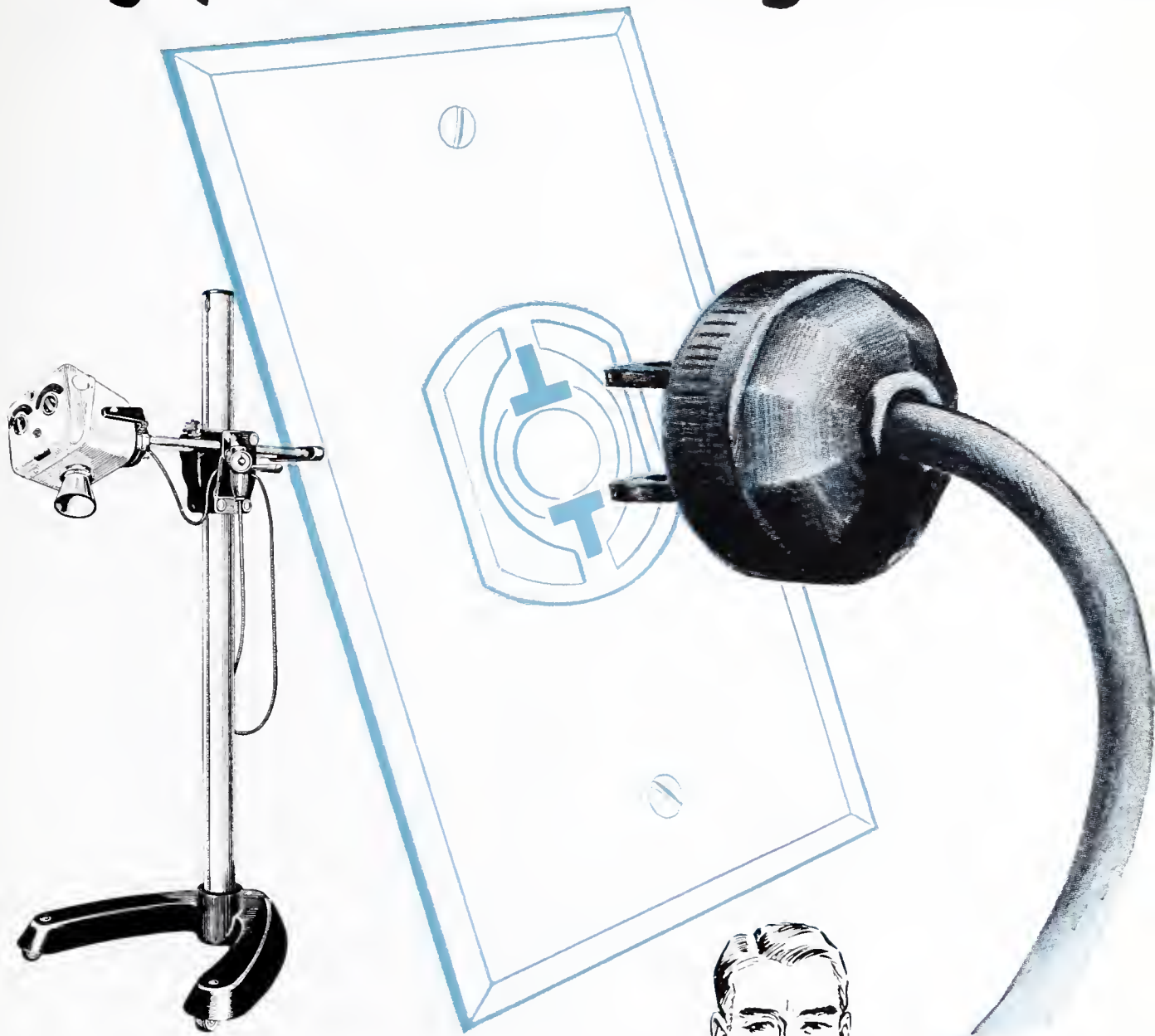
The ISOLETTE is equipped to operate on 110-120 volt AC 60 cycle.

ISOLETTE EQUIPMENT & DIMENSIONS

Dimensions of the ISOLETTE are: Length 34". Width 16½". Height 21½". Height of the mobile stand is 30". Weight of the unit, complete with stand and scale, is 111 lbs. Twelve feet of 5/8" I. D., 3/4" O. D. hose for outside air intake is provided with each unit.

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TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

EVERYONE concerned with tuberculosis control depends upon mortality figures as the mariner does upon the sun and stars. They show how far we have come and what remains to be done before tuberculosis finally disappears. The current figures show progress but they also bring to our attention the importance of more intensive work with older age groups in planning the attack upon tuberculosis.

TUBERCULOSIS MORTALITY IN THE UNITED STATES, 1947

In 1947, there were 48,064 deaths from tuberculosis in the United States. The death rate was 33.5 per 100,000 population, which was 8 per cent below the rate for 1946.

This decrease in the tuberculosis death rate continued the downward trend which has prevailed with few interruptions since 1910. Of the total deaths from tuberculosis in 1947, more than ninety per cent were attributed to respiratory tuberculosis. For both respiratory and nonrespiratory infections, mortality was much greater for nonwhites than for whites and greater for males than for females.

Death rates for tuberculosis in the white population and for nonwhite males were lower in the young adult years than in the older age groups,

while for nonwhite females the highest rates occurred in the young adult group. Among all young adults, the rates were higher for females than for males; among older persons, the rates were much higher for males. The rates for nonwhites were far above those for whites in all age groups except 75 years and over.

Death rates for tuberculosis were lower in 1947 than in 1939-41 for almost all population groups. In general, greater gains were made by females than by males, and by younger than by older persons. The only increases in rates were for males in the age groups over 55 years and for nonwhite females 65-74 years of age. Tuberculosis death rates in 1947 by State of residence ranged from 11.8 for Iowa to 100.0 for Arizona.

TUBERCULOSIS MORTALITY IN OLDER AGE GROUPS

Mortality statistics compiled for 1947 show that tuberculosis death rates have again declined in the United States. In 1947 the rate was 33.5 per 100,000, as compared to 36.4 in 1946. These gratifying figures show progress is still being made toward the goal—the disappearance of tuberculosis from the United States.

An analysis of the 1947 mortality data brings out a fact which is very significant. The proportion of deaths from tuberculosis among people over 45 years of age is steadily increasing.

For many years tuberculosis was a disease primarily of young adults between the ages of 15 and 44—people in the prime of life, wage earners, parents of small children, young people just starting their life work. In 1900, for example, almost two out of three of all the reported tuberculosis deaths were in this age group. Only one

out of four of those who died was 45 or over. By 1940, over half of the tuberculosis deaths reported still took place among people between the ages of 15 and 44, but deaths of those 45 and older had risen to 42 per cent of the total.

An important factor in this shift has been the fact that mortality rates have declined more slowly in the older age groups than in the younger and the greater number of older people in the country's population further accentuates the degree of change.

The shift toward older ages at death has great significance for tuberculosis case-finding activities. A study of a recent mass X-ray survey made in a Georgia county contains one of the few available tabulations of the ages of those X-rayed. It was disappointing to see the small percentage of older people who took part in that survey. Although 62 per cent of the population of the county in the age group 45-54 were X-rayed, the percentage fell rapidly in older age

groups; only 17 per cent of those 75 and over participated.

Obviously there are many reasons why people do not take part in mass surveys. Many of the very old people could not participate because of illness or incapacity. Many others not so old, however, failed to be examined because they think tuberculosis is a disease they have "out-grown." They must be cautioned that those over 45 are subject to tuberculosis just as younger people are.

Control workers should be reminded that older people form a major source of infection in the population. Special efforts are needed to discover the disease among those over 45 for the protection both of individuals and of the community. All men and women, young and old, should be urged to have periodic X-ray examinations either in mass surveys or as part of their annual physical examination by private physicians. Only by special emphasis and special efforts can all cases of tuberculosis be discovered, isolated, and brought under treatment.

Tuberculosis Mortality in Older Age Groups, Robert J. Anderson, M. D., Public Health Reports, April 1, 1949.

OBITUARY

WILLIAM C. PORTER, 70 years, died at his home in Ozark September 13th after a long illness which forced his retirement from practice two years ago. A graduate of the University of Arkansas School of Medicine in 1908 he first practiced at Coal Hill moving to Ozark in 1918. He was a member of the Masonic lodge, of the Knights of Pythias, active in organization of the River Valley baseball league and had served the Franklin County Medical Society as president for several terms. Surviving relatives are three sons and one daughter.

WILLIAM H. POYNOR, age 64, died at his home in Harrison September 12th. Born at Osage, Carroll County, he attended schools in Carroll County and graduated from the University of Arkansas School of Medicine in 1914. After rural practice for a few years he located in Harrison and later became surgeon with the Harrison Clinic in 1935. He was a member of the Masonic bodies and a past worshipful master of Boone Lodge, No. 314, F. & A. M., a member of the Rotary club and of the Methodist church. Reappointed to The State Medical Board of the Arkansas Medical Society in 1949, he was serving as president of that board. Surviving are his wife and two daughters.

PROCEEDINGS OF SOCIETIES

The Tenth Councilor District Medical Society met at Fort Smith September 13th, electing G. R. Siegel, Clarksville, President; Chas. W. Hall, Greenwood, Vice-president, and A. S. Koenig, Secretary-treasurer. The following scientific program was presented: "Guillan Barre Syndrome," Art B. Martin, Fort Smith; "Present Status of Thyroid Surgery," Thos. P. Foltz, Fort Smith; "Trouble Factors Associated with Treatment of Fractures," A. S. J. Clarke, and "Bening and Malignant Disease of the Pancreas," J. D. Olson and S. W. Hawkins, Fort Smith. The annual banquet was addressed by Louis T. Byars, Saint Louis, on "Treatment of Cancer of the Face, Mouth and Neck."

The Fifth District Medical Society will meet in Camden Monday, October 24th at 3:00 P.M. at the Camden Country Club. Program is as follows:

Remarks: Euclid M. Smith, President, Arkansas Medical Society; "Extra-Uterine Pregnancy," Henry B. Turner, Memphis; "Treatment of Acute Purulent Meningitis," James G. Hughes, Memphis; and "New Ideas in Surgery of Interest to the General Practitioner," R. L. Sanders, Memphis.

Dinner—Camden Country Club.

Public Meeting—7:30 P.M., Camden Municipal Auditorium.

Address—Allen Stockdale, New York City and Senator J. W. Fulbright.

The Pulaski County Medical Society was addressed September 12th by I. Meschan, on "The Radiological Approach to Diseases of the Chest (non-tuberculous)."

E. J. Easley, Secretary.

Craighead-Poinsett County Medical Society met in Jonesboro September 1st with the following scientific program: "Fractures of the Hip," Paul Ledbetter, Jonesboro, and "Humor at the Bedside . . . Elsewhere and Everywhere," J. H. McCurry, Cash.

Ouachita County Medical Society was entertained with a pheasant dinner in Camden September 1st at the home of Dr. and Mrs. Perry Dalton. The following scientific program was presented: "Reconstructive Surgery of the Nose," Ralph H. Riggs, Shreveport.

PERSONALS AND NEWS ITEMS

District Training Schools of the Arkansas Division, American Cancer Society, during September were addressed: Brinkley, W. G. Cooper, Little Rock; Jonesboro, A. D. Garner, Paragould; Batesville, J. J. Monfort, Batesville; Conway, Carl A. Rosenbaum, Little Rock; Fort Smith, L. A. Whittaker, Fort Smith; Hot Springs National Park, I. Meschan, Little Rock; Hope, James W. Branch, Hope; Camden, Perry Dalton, Camden, and Monticello, J. P. Price, Jr., Monticello.

Dr. and Mrs. Woodbridge E. Morris, Little Rock, spent a recent vacation in Connecticut.

Dr. and Mrs. E. C. Moulton, Fort Smith, spent a recent vacation in Colorado.

The Thompson Clinic, Fort Smith, has moved to new offices at 1610 South "B" Street.

Howell E. Leming, formerly with the Veterans Administration Hospital at Fayetteville, has opened offices for the practice of internal medicine at 106½ West Center Street, Fayetteville.

G. D. Murphy, Jr., and Frank Clark have been elected commander and post surgeon, respectively, of the El Dorado post of the American Legion.

J. J. Monfort, Batesville, represented the Society at hearings conducted in Washington July 22nd by the Senate Committee on Expenditures in the Executive Offices of Plan No. 1 proposed by President Truman to establish a cabinet office on welfare education and health.

Dr. and Mrs. J. M. Kolb, Clarksville, spent a recent vacation in eastern Canada.

Dr. and Mrs. T. P. Foltz, Fort Smith, spent a recent vacation in New Orleans.

R. B. Robins, Camden, addressed the Speaker's Training Conference, Illinois State Medical Society, Chicago, September 11th, on "Why We Are Here—The Menace of the Coming Months."

Dr. and Mrs. R. G. Kramer, Fort Smith, spent a recent vacation in Minnesota.

Euclid M. Smith, Hot Springs National Park, addressed the American Congress of Physical

Medicine at Cincinnati recently on "Balneotherapy in Arthritis."

Dr. and Mrs. M. E. Foster, Fort Smith, spent a recent vacation in Colorado.

BORN—On August 23rd, Robert Fontaine, to Dr. and Mrs. Fount Richardson, Fayetteville.

B. E. Barlow, Dermott, presided over one of the sessions of the Southern Tuberculosis Conference, Memphis, September 15-17th.

Thos. P. Foltz has been nominated for school director at Fort Smith.

W. L. Shippey, Fort Smith, has been appointed director of the Tri-State Society for Crippled Adults.

Karlton Kemp, Texarkana, and John McCullough Smith, Little Rock, have been elected surgeons of their respective American Legion posts.

Dr. and Mrs. M. E. Foster, Fort Smith, spent a September vacation in Colorado.

R. B. Robins, Camden, addressed the Association of American Physicians and Surgeons at Detroit October 28th on "The Doctor's Responsibility as a Citizen."

"Technic of Thyroidectomy," by J. Harry Hayes, Little Rock, appeared in The Journal of the International College of Surgeons, May-June, 1949.

In an effort to expedite the educational campaign of the Arkansas Medical Society and the Arkansas Public Expenditure Council against increasing government control of medicine, Bill Stover, president of William T. Stover Co., Inc., surgical supply dealer, has instigated a novel program to carry the message to the "grass roots" voters of Arkansas.

The William T. Stover Co., Inc., has financed a trip to England for Clovis Copeland, former Little Rock newspaper man assigned to the Medical Society by the APEC for the campaign, to obtain a first hand report on operation of Socialized Medicine in England.

The report will be distributed through more than 140 papers in the state by the Arkansas Press Association over a 10-weeks period.



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WOMAN'S AUXILIARY NEWS

The Auxiliary to the Independence County Medical Society met August 8th. Mrs. L. T. Evans presided over the business meeting. Each committee was reviewed and its goal emphasized. Reports included that of the last state meeting, and also of the workshop.

Tentative arrangements were made for a booth at the County Fair for the distribution of reading matter on the State Health Plan and private insurance against socialized medicine.

The next meeting will be held early in October.

Mrs. C. A. Taylor,
Publicity Chairman.

The Auxiliary to the Hot Spring County Medical Society had a joint dinner with the Medical Society at the Barlow Hotel, August 16, with Dr. and Mrs. N. B. Kersh as hosts. Dr. and Mrs. Barney Briggs were guests.

Following the dinner, the Auxiliary held a short business meeting at the home of Mrs. Kersh. The minutes of the previous meeting were read and approved. A motion was made and seconded to support the garbage disposal plan submitted by the city and that we put an ad in The Daily Record voicing our approval of the plan. Motion made and seconded to put on a drive against Socialized Medicine and to have a booth at the County Fair to give away literature explaining why we don't want socialized medicine.

There being no further business a short social hour was held.

Respectfully submitted,
Mrs. C. F. Peters, Jr., Pres.
Mrs. C. R. Ellis, Sec'y.

POPE-YELL COUNTIES

The Pope-Yell Counties Medical Auxiliary met in the home of the President, Mrs. Roy S. Milard, on August 17th. Six members were present. A short business meeting was held.

Mrs. William O. Young,
Publicity Chairman.

The itinerary for Mrs. Louis K. Hundley, State President to the Woman's Auxiliary, include the following visits.

September 13—Garland County Auxiliary.
October 10—District Meeting at Batesville.
October 19—Pulaski County Auxiliary.

Mrs. Gordon P. Oates, 4819 Hawthorne Road, Little Rock, has been appointed Council Woman

for District 8, succeeding Mrs. Byron A. Bennett, who resigned.

Officers and Committee Chairmen in the Auxiliary are requested to note the following changes in county presidents of Auxiliaries:

Crittenden—Mrs. J. H. Matthews, Earle.

Arkansas—Mrs. T. S. VanDuyn, Stuttgart.

Jackson—Mrs. M. L. Harris, Newport.

Ninth Councillor District—Mrs. Ross Fowler, Harrison.

Mrs. Joseph W. Kelso, Oklahoma City, President of the Auxiliary to the Southern Medical Association, has announced the appointment of Mrs. Louis K. Hundley, Pine Bluff, as Councillor for the State of Arkansas. Mrs. Hundley is to be on the program of the Auxiliary to the Southern at its convention in Cincinnati, November 14-16.

CORRESPONDENCE

Dear Sir:

Would you publish the following request?

The study of twins is of great value in providing information concerning the respective importance of hereditary predisposition and environmental influences in disease in man. The results of the use of this method have shown a hereditary predisposition to tuberculosis, diabetes, and tumor formation, and a high, medium or low intelligence quotient.

There is some *a priori* evidence showing an hereditary predisposition for peptic ulcer. Only six cases of the occurrence of peptic ulcer in the one or both of mono- or dizygous twins have been reported in the readily accessible literature. Since twins are born in 1 of 86 births and identical twins in 1 of 344 births and the general incidence of ulcer is from 5 to 10 per cent there should be plenty of material available.

I should like to ask physicians to cooperate in assembling such material by sending me cases in which (1) one or both twins develop peptic ulcer, (2) the site of the ulcer, (3) the age of onset of ulcer, (4) the type of twins (monovular or diovascular), (5) the sex of the twins, (6) the date of birth of the twins, and (7) the number and age of the brothers and sisters and the absence or presence of ulcer in each.

Yours sincerely,
A. C. Ivy, M.D.,
Department of Clinical Science,
University of Illinois,
1853 West Polk Street,
Chicago 12, Illinois.



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CARCINOMA OF PANCREAS

Carcinoma of pancreas constitutes about two per cent of all cancer. It is predominant in males in the ratio of four to one and the average age for both sexes is 60 years.

Two-thirds of all pancreatic malignancies are carcinoma of the head and the incidence of such malignancy is more than twice as great in diabetics with cancer as in cancer patients in general.

SYMPTOMS of carcinoma of the head of the pancreas are caused by compression or by invasion of neighboring organs. The onset is insidious with weight loss, asthenia, vague digestive disorders, gaseous distention, and nausea with later appearance of persistent jaundice with its accompanying symptoms of pruritus, clay-colored stools, dark urine and often enlargement of the liver. Pain is a frequent early, prominent, and persistent symptom in spite of the old teaching that painless jaundice meant carcinoma of the head of the pancreas.

DIAGNOSIS: The history, especially with

weight loss, indigestion, gaseous distention and upper abdominal pain, even before onset of jaundice and with or without a palpable mass in the epigastrium, should point to cancer of the pancreas.

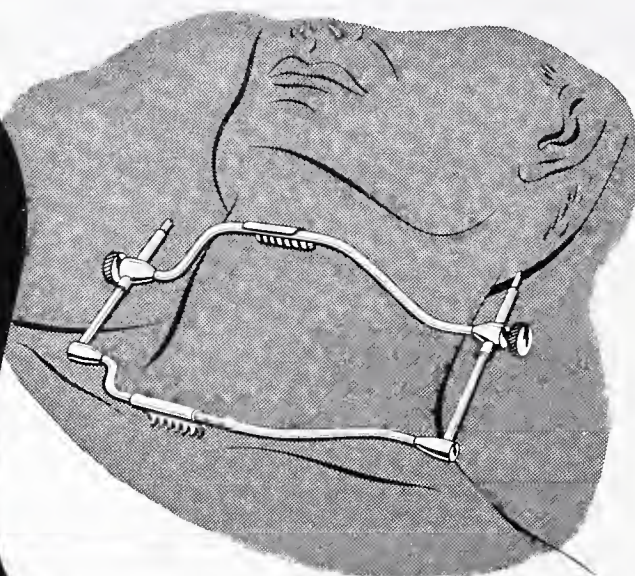
LABORATORY FINDINGS are helpful but inconclusive. Roentgenographic studies may show widening of the duodenal loop, with compression of the duodenum causing partial obstruction or ulceration of the concave margin of the duodenum.

The differential diagnosis can only be confirmed at exploratory laparotomy, which should not be deferred because of an indefinite clinical diagnosis.

CURATIVE TREATMENT consists of early exploratory laparotomy with resection of the head of the pancreas and the adjacent duodenum and anastomosis of the common duct, body of the pancreas and stomach to the jejunum. Palliative treatment for inoperable cases includes short-circuiting operations to relieve obstructive jaundice, and irradiation therapy.

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*See New Orleans Med & Surg Jnl., pages 10, 11, vol 101, No. 1, July, '48.

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LITTLE ROCK, ARKANSAS

RESOLUTION ON LIFE INSURANCE FEES

UNION COUNTY MEDICAL SOCIETY

El Dorado, Arkansas

At a recent meeting of the Union County Medical Society held in the Ming Room of the Garrett Hotel, El Dorado, Arkansas, the matter of requesting an upward adjustment of medical insurance examination fees was discussed at length by the members present.

A motion was made, seconded and unanimously carried that a resolution pertaining to this matter be drawn up and mailed to the House of Delegates of the Arkansas State Medical Society in order that some definite action could be taken by this body.

A committee of three doctors, Drs. D. E. White, J. M. Sheppard and A. D. Cathey, was appointed to prepare such a resolution. The following resolution was presented:

WHEREAS, The life insurance companies of the United States have been requested by various state medical societies, including the Medical Society of New Jersey, to increase the standard medical fee for regular life insurance examinations from \$5 to \$10, and to increase other medical insurance fees in like proportion; and

WHEREAS, These fees have not been changed in more than fifty years, and should be adjusted in recognition of changing economic conditions and advancing standards of medical practice; and

WHEREAS, This is a matter of national policy in which the action of single state societies is futile, and relief can be hoped for only by action of the American Medical Association; therefore be it

RESOLVED, That the Union County Medical Society request the House of Delegates of the Arkansas State Medical Society to go on record as an official act of the Arkansas State Medical Society as favoring an upward adjustment of examination fees as above suggested, and that officials of the State Medical Society negotiate with representatives of life insurance companies with the view of obtaining a nation-wide upward adjustment in the level of fees paid by life insurance companies to physicians for regular medical examinations and other medical services rendered on request of life insurance companies on behalf of their policyholders.

A copy of this resolution is to be mailed to Dr. W. R. Brooksher, Secretary of the Arkansas State Medical Society, well in advance of the next regular meeting of said society, in order that this matter may be acted upon by the House of Delegates of the State Society at said stated meeting.

D. E. White, M. D.,

Chairman Resolution Committee,

J. M. Sheppard, M. D.,

A. D. Cathey, M. D.

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ARNO E. TOWN, M. D., OPHTHALMOLOGY, Professor of Ophthalmology, Jefferson Medical College, Philadelphia, Pennsylvania.

JAMES ROSS VEAL, M. D., SURGERY, Associate Professor of Surgery, Georgetown University School of Medicine, Washington, D. C.

JOSEPH B. VANDER VEER, M. D., INTERNAL MEDICINE, Assistant Professor of Clinical Medicine, University of Pennsylvania School of Medicine, and Assistant Professor of Cardiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania.

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The JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Loryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60;
Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

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FORT SMITH, ARKANSAS, NOVEMBER, 1949

No. 6

CORONARY ARTERY DISEASE*

JOE W. VERSER, M. D.
Harrisburg

One of the few nice things about being a general practitioner is that when you are occasionally called upon to give a paper you can choose any subject to your liking, since you are expected to know so little about any of them and are considered an authority on none. I am certainly no authority on the subject for which I am about to speak, to the contrary, I choose this subject with the hope of learning more about this peculiar disease. It has always been a source of mystery to me why an apparently normal, healthy and especially young individual should develop a cardiac disability or die suddenly with heart disease. From the literature one might obtain the idea that coronary disease is a disease of middle and late life, yet in recent years we are seeing more deaths from coronary artery disease in young individuals. It is now estimated that one-third of patients who sustain an acute coronary occlusion are under 50 years of age. It is clear, then, that acute coronary diseases are important conditions in the relatively young.

Sometimes we are led to think of coronary artery disease as a Twentieth Century disease, to the contrary, it has existed for hundreds and probably thousands of years. There is evidence that it occurred among the early Egyptians. Ruffer writing on "Arterial Lesions Found in Egyptian Mummies 1580 B. C.—525 A. D.," stated, that Egyptians of 3,000 years ago not only suffered from calcification of the arteries, but that the atherosclerosis at that time was of the same nature as this disease today, that is, calcification following atheroma. Descriptions in the Bible are suggestive of attacks of acute coronary occlusion. An example, quoting from Deuteronomy 2:30 "In the case of Sichon the King of Cheshbon, the Lord hardened his heart and closed his heart, and he was therefore delivered unto your power." There are many writings from our earliest physicians on symptoms typical of coronary diseases, but it was Heber-

den who, as a result of observation of a hundred patients in his daily practice established the syndrome of angina pectoris as a clinical entity. His account written in 1768 reads like a recent textbook of the disease.

The etiology of coronary disease and the reasons underlying its increasing prevalence bring up interesting questions. It is now generally agreed that arteriosclerosis is the chief factor in the production of coronary disease. Naturally, one would then think of the classical causes of generalized arteriosclerosis, such as hypertension, diabetes, syphilis and, general wear and tear as being a precipitating factor in coronary disease. Yet it is now apparent that a vast number of people who die of coronary disease have no evidence of hypertension, diabetes or syphilis. In fact, many patients most seriously affected have a low blood pressure, and no organic disease outside the blood vessels themselves. Another interesting thought was projected by Leary in 1934, after detailed study in a representative group of cases of coronary sclerosis, in which he suggested the cause of arteriosclerosis to be due to a disturbance in the lipid metabolism of the body, rather than to an aging process. Wil-
lus, of the Mayo Clinic, has done further work along the theory that the cause may be due to a faulty fat metabolism particularly cholesterol. He reminds us of the fact that man is the only known creature that dies relatively young from coronary disease, and when he attains the advanced periods of life, arteriosclerosis is universally present. Furthermore, man is the only known creature who, from soon after birth to old age, partakes of a diet relatively high in fat, including such foods as milk, cream, butter, eggs and animal fats. If one is to subscribe to this theory he must explain the discrepancy of the disease in incidence according to sex. Since the ratio for man and woman is about 5 to 1 and we all know women partake of fat. It might be possible that women are endowed with a more active and perhaps a more nearly perfect lipid metabolism, which permits them to utilize completely the recurrent excess of stored lipid and to accomplish this without incurring arterial deposition. If we do not want to accept the

*Read before the Seventy-third Annual Session, Arkansas Medical Society, Little Rock, April 15, 1949.

theory of faulty lipid metabolism we can attribute the cause to heredity, and say it is a more or less "normal" way of dying on a genetic basis and let it go at that. To those who still persist that physicians and other professional people are peculiarly prone to coronary heart disease let me remind them that it has now been proven that no occupation has any priority on the disease.

A correct terminology in the discussion of coronary heart disease is important since there is confusion as to the terms, angina pectoris, coronary insufficiency, coronary thrombosis, myocardial infarction, etc. The simplest and most specific classification would be limited to the following: angina pectoris, acute coronary insufficiency and coronary occlusion.

Angina pectoris due to coronary artery disease is meant a transient episode of anterior chest pain brought on by exertion, excitement, food, cold, tobacco, etc. It is due to a temporary ischemia, and not accompanied by an acute pathological change in the myocardium. The duration of pain is short, the pain is frequently relieved by removing the exciting cause, usually effort. The pain may be of the classical agonizing, constricting type with radiation down the left arm, but often is a vague sensation of weight or fulness over the heart. The pain is relieved by nitroglycerin. Signs of shock are absent and changes in the heart sounds, heart failure arrhythmias and a drop in blood pressure are absent. Usually there are little, if any, changes on the electrocardiogram.

Acute coronary insufficiency is a syndrome of a more severe myocardial ischemia than angina pectoris and is associated with myocardial damage. The pathological lesion in coronary insufficiency is a focal disseminated necrosis in the subendocardium and papillary muscles, but no occlusion. The severity of the lesion is usually less and the signs and symptoms are usually less pronounced than one sees in coronary occlusion. Pain and shock may be absent. Heart failure, gallop rhythm, cardiac irregularities and fall in blood pressure are much less common than in coronary occlusion. Leukocytosis, fever, and increased sedimentation rate are usually present to some degree. Sudden death may take place. In fact, sudden death following excitement or exertion is often the result of a myocardial necrosis or infarction without occlusion. Coronary insufficiency has a characteristic electrocardiogram, namely, depression of the RST segments and T wave inversions, more frequently in Leads I and II. The changes usually return to normal fairly rapidly.

Coronary occlusion, or "thrombosis," with myocardial infarction is a very characteristic syndrome. It is a complete occlusion of a coronary vessel by a thrombus. Coronary occlusion is an end result of long standing coronary sclerosis. Usually is preceded by premonitory symptoms but is completely uninfluenced by external factors such as effort or excitement. In fact, this is a point of differential diagnosis from coronary insufficiency. The majority of attacks of coronary occlusion occur at rest or during sleep. The pain is not influenced by nitroglycerin and may persist for hours even after morphine injections. Shock is almost always present. Nausea and vomiting are very common. The blood pressure invariably falls. A change in heart sounds is a cardinal sign of acute coronary occlusion. Left heart failure is very common, leukocytosis, fever, and a rapid sedimentation rate are practically always observed. The electrocardiogram in coronary occlusion is quite specific. RST elevations appear which progress into deeply inverted T waves. Q waves are present early and the last to disappear. The electrocardiographic pattern takes about 4 weeks to reach its stable form, then begins to regress slightly, and will return to normal in a small percentage of patients in 3 to 12 months. The majority of patients however, reveal electrocardiographic evidence of coronary occlusion for years.

The treatment of coronary disease is certainly an individual problem. One might decide upon immediate treatment and length of bed rest more easily by fitting the patient into a severity scale as follows, severe, moderately severe, mild and very mild. Length of bed stay in the severe cases will probably average 4 to 6 weeks. Certainly the sedimentation rate and electrocardiogram are of value in determining this period of bed rest. As a rule once the sedimentation rate has lowered, and the electrocardiogram becomes stable, the patient can be allowed more freedom of movement.

Morphine should be given intravenously, in severe cases, in sufficient amounts, to control the intense pain, but not enough to depress respiration below 12 per minute. I believe the quicker pain is safely relieved the better for the patient. Oxygen is indicated if dyspnea and cyanosis are present.

Recently the use of anticoagulants, especially dicumerol, has been attracting wide attention. It is certainly of proven value in coronary occlusion but must be given under careful supervision. Unfortunately, when used its dosage must be controlled by daily estimation of the pro-

thrombin in the blood. The method is expensive and requires trained laboratory personnel. Before using dicumerol as a routine procedure its dangers must be balanced against its possible advantages.

Papavarine in 0.1 gm. doses four times daily, although of questionable value as a vasodilator, in my opinion, should be used. Aminophyllin, although frequently used, is another drug of doubtful value. After the most acute phase of the attack is over phenobarbital is useful to control apprehension and nervousness.

Digitalis is usually contraindicated. It should be avoided in the first few days. After the first week it may be tried cautiously if dyspnea persists or tends to increase. Never digitalize the patient rapidly. Sudden death during digitalization in patients with acute cardiac infarction occurs entirely too often. Heart stimulants such as coramine or metrozol should be strictly avoided. Sudden stimulation of the heart already laboring under a heavy strain may precipitate a sudden death.

After the patient has recovered from the pain and shock of a coronary attack the real problem for the physician has just begun. In talking to a patient we should avoid terms like "thrombosis," "blood clot," and "heart attack," which tend to cause apprehension. We should, however, explain to the patient what has happened in such a manner as not to create fear. At the end of the period of rest following an acute coronary attack the unstable patient will often confront the physician with a rather complex assortment of symptoms, some of which are organic and some of which are induced or magnified by apprehension. This is one of the most delicate situations we are called to handle, and many errors have been made in each direction. Certainly we should not minimize those symptoms referable to angina of effort. We have had excellent results with testosterone in 25 mg. doses once or twice weekly in some of the more unstable patients.

When a man first develops coronary disease he is apt to be afraid. A new danger has come over his horizon. With the physician's help he will become accustomed to it and will not experience so much mental suffering. It is our duty to help him through the first stage of the new fear as wisely and gently as we can, and to point out to him from the beginning that he may be rehabilitated and lead a long and useful life. His life may be less active physically but it may be more peaceful. As a result it may actually be a happier existence than that which he was forced to relinquish.

CARE OF POLIOMYELITIS AT THE LOCAL LEVEL

WILLIAM A. REILLY, M. D.
Little Rock

General hospitals can adequately take care of poliomyelitis. The degree of contagion in this disease is very low, especially during the period of the nervous system manifestations. At this stage, the occurrence of infection from one patient to another is very negligible and possibly nonexistent. The occurrence of two patients in one family is due to their common exposure to a third party who usually does not have active disease. After the disease is active, it is impossible to find the virus in the nose and throat secretions or the spinal fluid; even the brain, after the first week from on-set, is rarely a site for the virus. It is true that the virus is in the stools in some for as long as six weeks from on-set; nevertheless, cross infections in contagious wards and convalescent homes does not occur. General hospitals could handle these patients by setting up a secluded unit for isolation. Running water, mask and gown technique with attendants washing their hands between handling of patients and careful disposal of feces will readily meet isolation requirements. Rooms with one to three patients would be ideal, however, numerous patients can be put into one general ward with adequate separation by screening.

There seems to be some hysteria among physicians and nurses, as well as the public, which should be abolished. Certainly no hospital should suffer from a sentiment that the patient's family does not wish to enter their relative in a hospital giving care for poliomyelitis, for fear of contagion. The care of these patients has now been fairly well standardized and the majority of the general practitioners should be able to master such isolation and therapeutic procedures in their own local communities. The more complicated or desperately ill patients can be sent to a better equipped medical center for poliomyelitis care.

Further advantages of care at the local level are the following: abolishing of public hysteria; giving confidence to the patient; reducing the cost of care and sparing the ill patient the trauma of a long trip, which often is very fatiguing, induces a worse condition and sometimes is quite dangerous. Such a long trip occasionally makes it necessary to place patients into respirators, which otherwise may have been prevented.

Perhaps Arkansas will not be afflicted with this year's great number of cases for some years.

(Continued on Page 112)

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THERE is a great need for a trustworthy set of rules to protect the people in contact with tuberculosis patients and an even greater need for a more general application of existing methods in sanatoriums, in hospitals, and in homes.

A CRITICAL ANALYSIS OF ASEPTIC TECHNIC FOR TUBERCULOSIS

The Essentials of Asepsis

"Aseptic technic" is a routine for protecting the contacts of tuberculous patients. It consists of a number of logical methods to prevent the spread of infection which are applied to the patient, to his contacts, and to his environment. It involves facilities for isolation, placement of the patient, and care of the patient. According to the circumstances, the routine may be limited to a few obvious essentials, or include a complete list of all possible methods.

The usual source of infectious material is the respiratory tract. Contamination may occur in three ways—**direct**, by contact with the patient; **indirect**, by the handling of contaminated materials, and **air-borne**. The newer analyses of air-borne transmissions have shown that bacilli may travel by: **droplets**, larger than 0.2 mm, which quickly clear from the air by gravity; **droplet nuclei**, less than 0.1 mm, which quickly evaporate, continue to float, and are a dangerous cause of infection; and **dust** which may contain dried droplets.

Isolation technic is not the only means for control of tuberculosis in general hospitals. Other approaches include routine chest X-ray examinations of all patients and personnel to uncover all active cases of tuberculosis and the provision of facilities for the care and isolation of cases of tuberculosis when found.

Principles of Protection

The ways to avoid contamination are to reduce the number of bacilli expelled by the patient, to reduce contact between attendants and patients, and to apply a routine of aseptic precautions. One must plan to: immobilize the bacilli near their source, collect the secretions, protect the contacts, and cleanse the environment by appropriate means.

Education and training must reach not only the patient and his visitors but the staff and all employed personnel in the hospital whose duties bring them into contact with the patient or with material contaminated by his secretions. A detailed routine must be arranged for their care and protection, and carried out without deviation.

Excessive Hazards

There are a number of places in a precautionary routine where the hazard of contamination or the chance of non-observance is greater than others. In part these hazards are due to the nature of illness, but in part to human failings. They include: lapses in self-care by the patient, personnel, or visitors, and the uncovered cough, sneezing, laughing, talking, and throat-clearing.

Some of the hazards are relatively unimportant, but a few of them represent notable **flaws or weak spots**. The **habits of the patient** are probably the most important factor in an aseptic routine. The patient must understand the theory of contamination; he must be willing to help; he is responsible for catching the bacilli near their source and disposing of them; he must practice the methods until habits are formed; and the habits must be constant and invariable.

The **respiratory tract of persons in contact with the patient** must be considered exceptionally vulnerable. Since attendants must care for the patient and also must breathe, the entry of bacilli should be prevented by all possible means. The correct wearing of masks, and their

"POLIO"—(Continued from Page 111)

It is urged that the local communities be prepared well in advance—particularly in the southern part of the state—for such an emergency. During this year it would have been impossible in Little Rock to hospitalize everyone needing hospitalization, if all such cases had been brought here. As a matter of fact, many such cases (20%) could be taken care of at home, particularly those with very mild paralysis. Isolation and proper care are feasible for them at home.

construction and composition, are of utmost importance.

The uncertain value of several antiseptics and methods is a weak spot in the technic. Among the antiseptics only the alcohols, cresols, and formaldehyde have any appreciable effect on the tubercle bacillus, and only the first two are practical. The value of cresol compounds is at present a matter of dispute. They are being tested by modern methods in order to determine their efficiency and limitations.

Whether soap is simply an aid to ablution or is bacteriostatic is not known. Detergents (including soaps) are used for cleaning of rooms, yet they are not considered to be antiseptic for tubercle bacilli by authorities. Hand-washing is a standby in aseptic technic. In the washing of clothes, soap acts only as a remover of dirt. Sterilization depends upon the recurrent exposure of white clothes to temperatures above 140° F. for a total of at least 30 to 40 minutes. This formula is generally used in standard laundry practice.

Vacuum cleaners have recently been suggested for cleaning rooms containing tuberculous patients but have not been sufficiently tested for efficiency.

Face masks have not been completely studied. They have two uses—for the patient and for the person in contact. Masking of those in intimate contact with patients is necessary, especially when they are grossly infectious, liable to cough, or careless.

The disinfecting value of ultra-violet light is in dispute, chiefly due to the variation in sources, intensities, and the quality of contaminated surfaces.

New and Valuable Methods

Several methods and materials have only recently been proved valuable and put into use. The use of oil to reduce the dust, and the use of alcohol as a skin antiseptic are the most notable. Certain "odorless cresols" (which actually are phenols) have shown promise and are being tested.

Summary and Conclusions

The majority of protective methods and materials are good. They are logical, efficient, and can be easily applied. There are several valuable new procedures. A limited and incomplete application is the greatest deficiency which has been noted. A correction should not wait until perfection of the precautions; it should be made now, in every hospital and sanatorium, and

pushed to wide usage in the care of patients at home.

A Critical Analysis of Aseptic Technic for Tuberculosis, William H. Oatway, Jr., M. D., Arizona Medicine, May, 1949.

RESOLUTION

WHEREAS, an all-wise Providence has seen fit to remove from our midst our valued co-worker and a faithful member of the Pulaski County Medical Society since 1939, Dr. Charles C. Anderson, we, the members of the Society mourn and deeply regret his sudden death.

WHEREAS, as a physician in his chosen field of general practice of medicine, he attained a great measure of distinction and won the respect of his colleagues as well as the gratitude and love of a host of sorrowing people.

BE IT RESOLVED, that the Pulaski County Medical Society express to his family the esteem in which he was held as a member of the Society and its heartfelt sympathy to the family at the untimely loss that they have sustained; that a copy of this resolution be made a matter of record in the minutes of this meeting; that a copy be sent to the family and a copy be sent to the Journal of the Arkansas Medical Society.

This Resolution is respectfully submitted to the Society by your Committee.

T. Duel Brown, M.D.

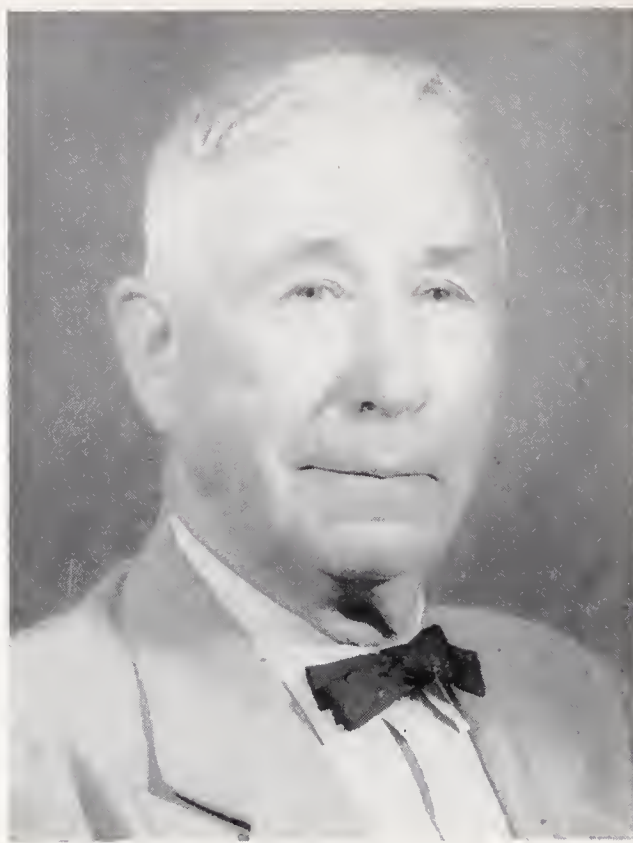
Ellery C. Gay, M.D.

Edgar J. Easley, M.D.

OBITUARY

ISAAC G. JONES, DeQueen, age 60, died September 18th after an illness of about a year and a half and which forced his retirement July 1st. A graduate of Vanderbilt University School of Medicine in 1919, he had been chief surgeon and medical director of the Dierks Lumber and Coal Company for 20 years, city and county health officer for 16 years and a division surgeon for the Kansas City Southern Railway for 13 years. He established the DeQueen Clinic with Dr. G. L. Kimball in 1941. Surviving are his wife, two sons, a brother and a sister.

D. C. ROBERTS, age 69 years, Berryville, died October 2nd. A graduate of the University of Arkansas School of Medicine, he had lived in Carroll county all his life except for several years in which he engaged in practice at Fayetteville. Surviving relatives are his wife, two sons and two daughters.



T. E. RHINE, M. D.

T. E. Rhine, Thornton, who will be presented as the nomination from Arkansas for the 1949 American Medical Association award of "Doctor of the Year," began practice at Thornton March 21, 1908, as a typical "horse and buggy doctor." He has lived in the community as an active, conscientious, sincere physician and citizen. He has been both a professional and a civic leader; a physician who has served humanity in the saddle bag day as well as in the day of penicillin and streamlined automobiles, taking the best of all as offered for the good of his patients.

One of the original Fifty-Year Club in the Arkansas Medical Society, beloved by patient and physician alike, his has been a life truly of service.

Arkansas is proud to present T. E. Rhine, Family Doctor, to the American Medical Association, as one worthy to be chosen as the "Doctor of the Year."

ARKANSAS RECEPTION AT WASHINGTON INTERIM SESSION OF THE AMERICAN MEDICAL ASSOCIATION

Plans are being completed for the reception which the Arkansas Medical Society will hold at the Mayflower Hotel, Washington, December 5th, during the interim session of the American Medical Association. Guests of honor will be distinguished Arkansans in Washington, members of Congress from Arkansas and Dr. T. E. Rhine, Thornton, nominated by the Arkansas Medical Society as its candidate for the American Medical Association award as "Doctor of the Year." Guests will be members of the House of Delegates and officers of the American Medical Association.

Members who will attend the Washington session are urged to be in attendance as hosts for the reception.

COUNTY ADVISORY MEMBERS TO THE AUXILIARY

County medical societies have been requested by Dr. L. K. Hundley, Chairman, Advisory Committee to the Woman's Auxiliary to the Arkansas Medical Society, to appoint a member-advisor to their county Auxiliary unit and to submit these names to the office of the executive secretary. This action is in accordance with a recommendation of the Committee on the Auxiliary approved by the House of Delegates at the 1949 annual session.

FOR SALE—Three-room office and equipment. Desirable location in Berryville, Arkansas. Equipment may be purchased separately. Write: Mrs. D. C. Roberts, Berryville, Arkansas.

THE JOURNAL

OF THE
ARKANSAS MEDICAL SOCIETY

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NEWS—Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to the membership.

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EDITORIAL

THE DEPARTMENT OF JUSTICE INVESTIGATION

The Board of Trustees of the American Medical Association has issued a public statement "protesting the use of a police arm of the Government—namely, the Anti-Trust Division of the Department of Justice—in a campaign to discredit American medicine and terrorize physicians into abandoning their opposition to Compulsory Health Insurance."

The statement revealed that 16 State and County Medical Societies, and other medical organizations, including the A. M. A. itself, have been made the targets for investigations by the Anti-Trust Division of the Justice Department during the past 30 days.

The medical groups suddenly brought under investigation, it was announced, include the following:

American Medical Association, New York State Medical Society, Utah State Medical Association, Washington State Medical Society, Arkansas Medical Society, the Oklahoma State Medical Association; Michigan Medical Service,

a Blue Shield prepaid medical care plan; Pulaski County Medical Society; Los Angeles County Medical Society, California; Beckham County Medical Society, Oklahoma; Wayne County Medical Society, Michigan; Harris County Medical Society, Texas; King County Medical Society, Washington, and the New York County, Nassau County and Queens County Medical Societies in New York State.

The A. M. A. statement follows:

"This is an official statement of the Board of Trustees of the American Medical Association, protesting the use of a police arm of the Government—namely, the Anti-Trust Division of the Department of Justice—in a campaign to discredit American medicine and terrorize physicians into abandoning their opposition to Compulsory Health Insurance.

"The A. M. A. has opened its records to the Justice Department, without reservation, and medical societies throughout the country undoubtedly will do likewise, but we intend to keep the public fully informed of developments, as we are convinced that these are not bona fide anti-trust investigations, and that the American people will not tolerate police state methods in this country.

"We would be naive, indeed, if we ignored the political implications of this sudden rash of investigations, attacking medical societies, at a time when the administration is doing its utmost to stifle opposition to its proposed system of government-controlled medical care.

"This scheme, it is specifically provided, would be a government-monopoly, to which every citizen would be compelled to contribute, and which would destroy all the hundreds of voluntary health insurance systems which now provide prepaid health care for more than 61,000,000 of the American people.

"Certainly it will be a travesty on justice if the Anti-Trust Division of the Justice Department can be used to silence opposition to the creation of a government-trust in medicine.

"The American people, we believe, will hardly think it a coincidence that these anti-trust investigations should be ordered at this time—after there have been repeated threats that medical groups would be 'investigated' because of their opposition to socialized medicine.

"The chronology of events, since the American Medical Association decided to make a nationwide campaign against compulsory health insurance, and in behalf of voluntary health insurance, is, we believe, of real significance.

"In November, 1948, the A. M. A., at its mid-winter meeting, voted to collect funds from

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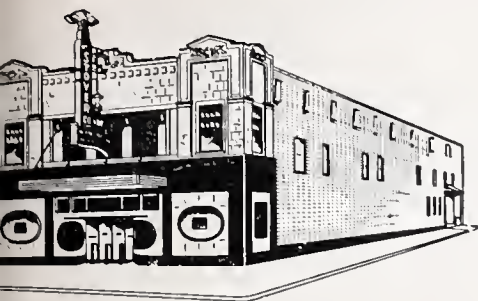
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its members to finance a campaign of public education on this issue. A public announcement was made to that effect.

"Only a month later, in December, agents of the Department of Justice called on the Chicago Medical Society, seeking to check the Society's records in connection with an alleged anti-trust investigation.

"During the February session of the Board of Trustees of A. M. A. in the early hours of February 10, the board room was broken into and records of the board were thoroughly searched by persons unknown. Brief cases of the trustees, left in the room, also were searched. Entrance was gained through a window. The facts indicate this was a search for information, rather than an ordinary burglary. Certainly no friends of medicine would take this means of obtaining medical data.

"A few weeks later, toward the end of February, administration leaders began threatening medical societies and medical men with 'investigation' as part of their campaign to discredit and intimidate the medical profession. Since then, there hasn't even been much attempt to disclaim the political nature of these investigations.

"On February 28, 1949, for example, one of the national press associations carried a dispatch from Washington quoting government officials as stating that anti-trust actions would be started against 'several' medical societies soon after the compulsory health insurance drive was started in Congress.

"The implication was plain that the 'investigation' would be part of the administration's campaign for its socialized medicine scheme.

"The threats made then are now realities. An epidemic of 'investigations', aimed at medical societies and voluntary medical care plans, has broken out in widely separated states and cities all over the country.

"We want it clearly understood that we believe this attack on the medical profession stems from the Anti-Trust Division of the Justice Department and political string-pullers who have exerted influence on that agency. We believe it to be an outrageous abuse of public power which far transcends in gravity the issue of compulsory health insurance, vital as that issue is.

"We recognize that politically-motivated attacks have been made on many other groups by this division of the government—and we invite their cooperation with American medicine in an effort to alert the American people to the

seriousness of this trend toward police state methods. If the police arm of the government is used to intimidate doctors and others, and this abuse of power goes unchallenged, it may next be used to terrorize publishers or grocers, farmers or lawyers, Catholics or Jews, or any other minority in the nation."

RANDOM THOUGHTS OF THE SECRETARY

September 15th. For the first time this season over Winslow mountain with fog hindering progress.

September 23rd. Meeting with members of the state press association in informative discussion of mutual problems, a conference which was long, long overdue.

September 25th. Roy Millard takes seriously appointment as general chairman and calls together all but four of the sub-committee chairmen at Russellville today, a meeting which clears the way for enthusiastic and profitable committee activity.

September 27th. Modesty prevents mention of the fact that the alert delegate shown on the front row in LOOK magazine's article on the American Medical Association is one of the Arkansas delegation.

September 30th. Aboard the airliner this morning, a beautiful day with our spirits never higher, to be suddenly stricken with an unrelenting, agonizing epigastric pain, for which relief is not available and for the diagnosis of which we can assemble sufficient fearful possibilities. Realizing the situation calls for immediate treatment, we ask for Dan Autry to meet us at Adams Field which he does, taking over our personal affairs with all completeness, giving us relief and we are hospitalized for the second time in our life, both admissions in A. D. 1949.

October 1st. For us, St. Vincent's Infirmary becomes the flag-bearer of hospitals: gracious and considerate kindness to us throughout these troubled days shall cause us to ever remember these good folks. In the afternoon restrictions permit radio listening and neither the thrilling North Carolina-Georgia nor the Yankee-Red Sox conflict accelerate our pulse rate and we turn off the baseball game hoping that some day we may meet "Dutch" O'Neal who must sell many used cars for \$250 down.

October 2nd. With glimpses during our hospital stay of Henry, Hollenberg, Rosenbaum, Kumpuris, Kilbury, Hoyt Allen, Cooper, Mahoney and Harry Hayes, Autry and Compton relax on our confinement and permit our return homeward stretched out on the car's rear seat, a departure perhaps more pleasing to the attending physicians than to the attended one, but again thankful for courtesies and sincere interest given by Autry and Compton to our major illness and this is what we mean by our wish that there may be more of the art of medicine along with the science.

October 5th. Spending the days recumbent, or somewhat so, at home, our spirits none too dampened but proving a trial, we presume, to the lady who took us for better and probably got her share of the worse.

October 7th. Blair becomes the cardiologist with the biggest heart of all as he gives us the "green light" today and we step forth to resume activity in our little field, perhaps not so active as in the past, but as ever undisturbed and happy over our lot.

October 10th. The days occupied with activity in a

PERSONALS AND NEWS ITEMS

Dr. and Mrs. O. J. T. Johnston, Batesville, spent a recent vacation in Rochester, Minnesota.

Paul L. Mahoney, Little Rock, recently attended the American Academy of Ophthalmology and Otolaryngology Session in Chicago.

Stanley M. Gates, Little Rock, attended the postgraduate study course of the American College of Chest Physicians held in Chicago September 19-23rd.

R. E. Smallwood, Fayetteville, is attending Harvard University School of Public Health, majoring in the field of epidemiology.

Dr. and Mrs. W. J. Ketz, Batesville, spent a recent vacation in Houston.

S. A. Southall, Lonoke, was honored as one of the senior graduates of the University of Tennessee at the recent commencement exercises.

Lamar McMillin has moved to new office at 1311 Louisiana, Little Rock.

Paul L. Mahoney, Little Rock, spent two weeks in postgraduate study on rhinoplastic surgery at Los Angeles during September.

Earl Parsons, Jr., has opened offices for the practice of psychiatry at 805 West Fourth Street, Little Rock.

"Streptomycin Therapy for Pertussis" by Vida H. Gordon and Philip J. Almaden, Little Rock, appeared in the March, 1949, issue of The Journal of Pediatrics.

C. Lewis Hyatt, Monticello, has been elected a Fellow of the American College of Chest Physicians.

slower tempo with greatest enthusiasm toward plans for the hunt in Idaho, our project which now receives not only the taunts of professional brethren but those of the laity as well, as snow maroons many a hunter in that area.

October 14th. With Bill, junior, vacation-bound to the Salmon River country of Idaho, one of America's few last frontiers, a primitive area, where there will be no talk of reorganization plans, FBI investigations or the like, but where the bugling of the bull elk will be the major listening and the successful stalking of which during the coming week will be great compensation even for frost-bitten ears and toes.

The Tri-State Medical Assembly in Texarkana, October 5th, and the Organization Conference of the Colorado State Medical Society in Denver, October 7th, were addressed by R. B. Robins, Camden, on "Responsibilities of the Doctor as a Citizen."

In attendance at the Mississippi state meeting of the American College of Physicians at Jackson October 8th were: A. A. Blair and J. Kenneth Thompson, Fort Smith; H. T. Smith, McGehee, and James W. Leatherman, Hot Springs National Park.

C. G. Leverett, McGehee, has been elected a vice-president of the Arkansas Association, Amateur Athletic Union.

Among those in attendance at the organization meeting of the Southwest Surgical Congress at Houston September 25-27th were: Earle H. Hunt, Clarksville; A. F. Hoge, I. F. Jones and Fred H. Krock, Fort Smith; M. C. Hawkins, Searcy; L. H. Good and W. B. Harrell, Texarkana; John H. Wilson, Magnolia, and H. Fay H. Jones and R. T. Smith, Little Rock.

Dr. and Mrs. D. W. Goldstein, Fort Smith, spent a recent vacation at Edgewater Gulf, Mississippi. Dr. Goldstein also attended the meetings of the American College of Physicians at Jackson, Mississippi, and the Frisco System Medical Association at Pensacola, Florida.

PROCEEDINGS OF SOCIETIES

The Second Councilor District Medical Society met in dinner session at Batesville October 10th for the following program: "The British Medical System," Mr. Clovis Copeland, Little Rock; "Pediatric Emergencies," Barney P. Briggs, Little Rock, and "The Office Diagnosis and Treatment of Vaginitis," Deane Wallace, Little Rock.

The re-organization meeting of the Tri-State Medical Assembly in Texarkana October 5th was addressed by Jack R. Ewalt, Galveston, "The Differential Diagnosis of a Major and a Minor Psychosis"; Willis E. Brown, Little Rock, "The Border Line Pelvis"; William A. Reilly, Little Rock, "Endocrine Problems in Childhood"; E. A. Smolik, Saint Louis, "Management of Acute Head Injuries"; Thorpe Ray, New Orleans, "The Management of Congestive Heart Failure," and

Champ Lyons, New Orleans, "Recent Advances in Surgery." Officers elected are: Chas. R. Gowen, Shreveport; Shelton Boyce, Shreveport, Richard Granberry, Marshall, Texas, and James Guthrie, Camden, Arkansas, vice-presidents, and John W. Jones, Texarkana, secretary-treasurer. The next session will be held at Shreveport.

The Pulaski County Medical Society was addressed September 26th by Clovis Copeland, on "Socialized Medicine in Practice in Great Britain."

E. J. Easley, Secretary.

The Sebastian County Medical Society was addressed October 11th by W. G. Cooper, Little Rock, on "The Acute Abdomen."

J. B. Stewart, Secretary.

The Pulaski County Medical Society was addressed October 3rd by W. E. Morris, "Rickettsial Disease in Little Rock."

E. J. Easley, Secretary.

The Five County Medical Society met at the Nashville Hospital September 22nd for the following program: "Care of the Well Baby and Some of the Problems Which Arise," Jo Cooper, El Dorado, and "Pitfalls in the Diagnosis of Fracture," Joe Norton, El Dorado.

Norman Peacock, Secretary.

The Arkansas Society of Clinical Pathologists met at Little Rock September 24th, electing the following officers: President, D. C. Lee, Hot Springs National Park; Vice-president, A. S. Koenig, Fort Smith, and Secretary, Lloyd Wilbur, Little Rock.

The Third Councilor District Medical Society met in Helena October 6th for the following program: "Management of Lesions of the Gastrointestinal Tract," Lyle Motley, Memphis; "Surgical Considerations in Gastrointestinal Tract Lesions," Harwell Wilson, Memphis; "General Aspects of Malignancy of the Skin," Fred Hames, Pine Bluff, and "Management of Congestive Heart Failure," S. C. Fulmer, Little Rock. A banquet followed the scientific session.

F. S. Dozier, Secretary.

The Pope-Yell County Medical Society met in Russellville on October 13th with the following scientific program: "The Diagnosis of Tuberculosis," A. B. Dickey, State Ana Sanatorium.

WOMAN'S AUXILIARY NEWS

The Medical Auxiliary held a joint dinner meeting with the Garland County Medical Society September 13 at the Belvedere Country Club. The tables were beautifully decorated with Autumn flowers. Silver tapers and a large silver bowl of flowers at the speaker's table. Mrs. Leeman King, president, presided at the business meeting, following the dinner. Plans were discussed for a benefit bridge to be held October 21st at the Majestic Hotel. The Auxiliary voted to sponsor a booth at the Garland County Fair September 27-October 1, and, also a booth at the Convention of the B. P. W. Club, October 7, 8, 9. The program was turned over to Mrs. Louis K. Hundley, Pine Bluff, State President of the Auxiliary to the Arkansas Medical Society. Mrs. Hundley discussed the program and project of the Auxiliary for the coming year. There were twenty members present, and out-of-town guests for the evening were: Mrs. Louis K. Hundley, Pine Bluff; Mrs. Tom Mitchell, Memphis, Tenn., and Mrs. Randolph Ellis, Malvern, Ark.

Mrs. L. E. Reed, Publicity Chairman.

The Pope-Yell County Medical Auxiliary met at Woodye Plantation for a monthly dinner meeting. Dr. and Mrs. Gordon P. Oates, of Little Rock, were guest speakers. Dr. Oates gave a very interesting talk on Compulsory and Voluntary Health Insurance. Mrs. Oates gave valuable information on organizing a booth for the County Fair. Dr. Robert H. Hood, president of the Pope-Yell County Medical Society, appointed Dr. J. Arnold Henry, of Russellville, as Advisor from the Medical Society to the Auxiliary. Our Auxiliary had a booth at the Pope County Fair for distribution of literature on Compulsory and Voluntary Health Insurance.

Mrs. William O. Young,
Publicity Chairman.

The Auxiliary to the Washington County Medical Society met Tuesday, September 6, at the Washington Hotel for a dinner meeting. Eighteen members were present. Plans were made for a booth at the County Fair, to distribute anti-socialized medicine literature.

Mrs. P. L. Hathcock, Sec'y.

The following is a report from Mrs. Gordon P. Oates, Little Rock, Arkansas, on exhibits she has arranged for State, District and County Fairs.

I have sent letters and cards with full details

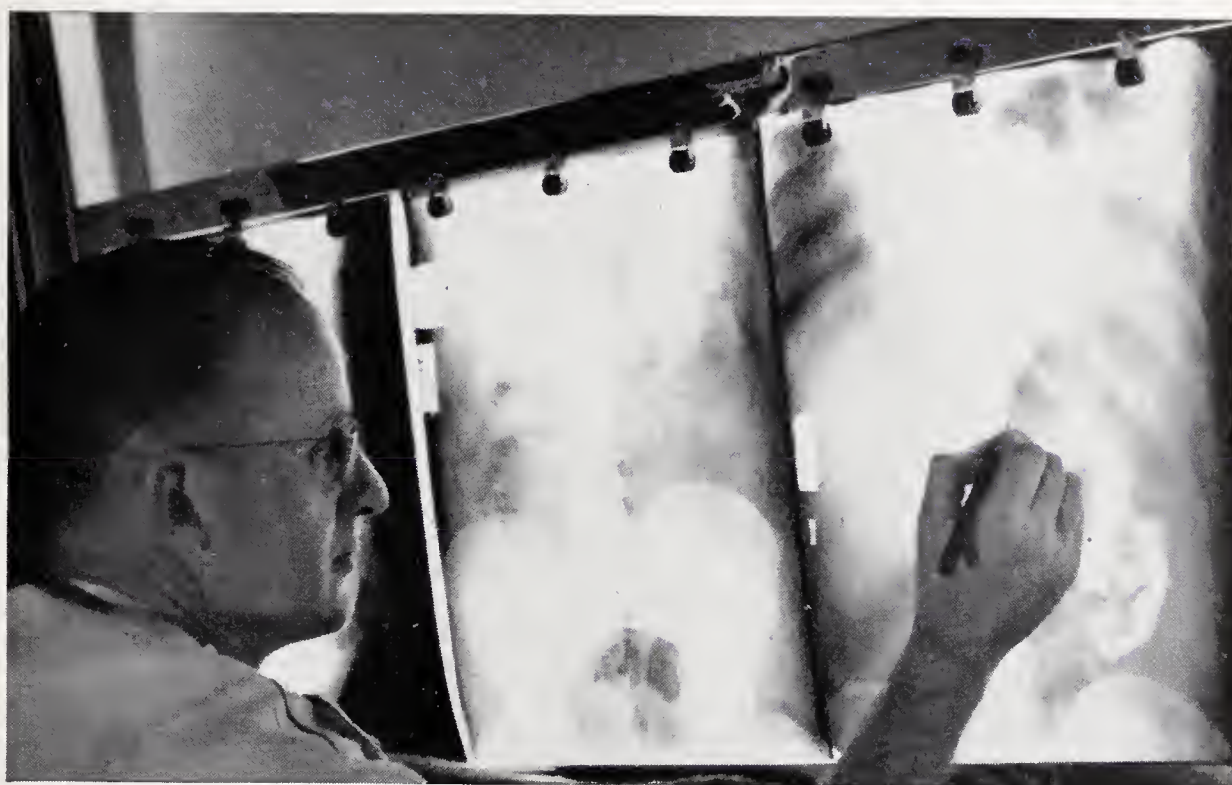
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RESEARCH IN THE SERVICE OF MEDICINE

for setting up booths to about fifty county fairs, three district fairs, and one state show. Eight of these fairs have already taken place, with about twenty or more to take place each week of this month, with the exception of a few in October. I am still receiving orders, so my report is incomplete. Each Auxiliary, member-at-large, or doctor in locality is taking care of setting up the booth, decorating the booth, and having people scheduled to man the booth to distribute anti-socialized medicine literature. Each Auxiliary is taking on this project as one of their major acts to inform the public as to what Socialized Medicine means.

Besides the County Fairs, booths have been set up at the Lions Convention that met in May; the Civitan Show, to meet the 17th, 18th, 19th of this month; and the horse show in Pine Bluff in October; and the B. & P. W. Nine State Conference to meet in Hot Springs in October.

The climax of the County Shows will be the Arkansas State Livestock Show in Little Rock on Oct. 3rd, at which time we intend to have a large booth with displays, and manned by the Pulaski County Medical Auxiliary to distribute literature during the eight days of the show.

Mrs. Gordon P. Oates,
Chairman, Exhibit Committee.

The Auxiliary to the Columbia County Medical Society had its first fall meeting Thursday, September 22, at the Magnolia Inn. Luncheon was served to eight members. The president, Mrs. Joe Rushton, presided. She introduced one new member, Mrs. Evan G. Houston. Minutes were read by the secretary, Mrs. G. F. McLeon, and dues collected from those present for the new year. It was decided that our project for the year would be decorating the nursery in the City Hospital. Committees were appointed to attend to details of a Benefit Bridge party to be given in October for the purpose of raising funds for this project. Plans were made for a member to be present at all times during the Columbia County Livestock Show at our booth for distributing literature on Voluntary Health Insurance. Meeting date of the Auxiliary was changed due to conflict with other Civic Clubs, and it was decided that a joint meeting with the County Medical Society would be the best arrangement. Mrs. Howard Kitchens, of Waldo, was elected to serve as vice-president due to vacancy caused by resignation of Mrs. T. H. Jones who moved away. In closing the president thanked all members who assisted the tem-

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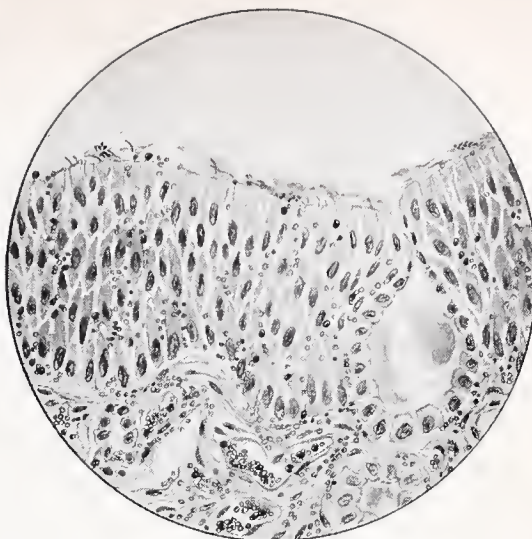
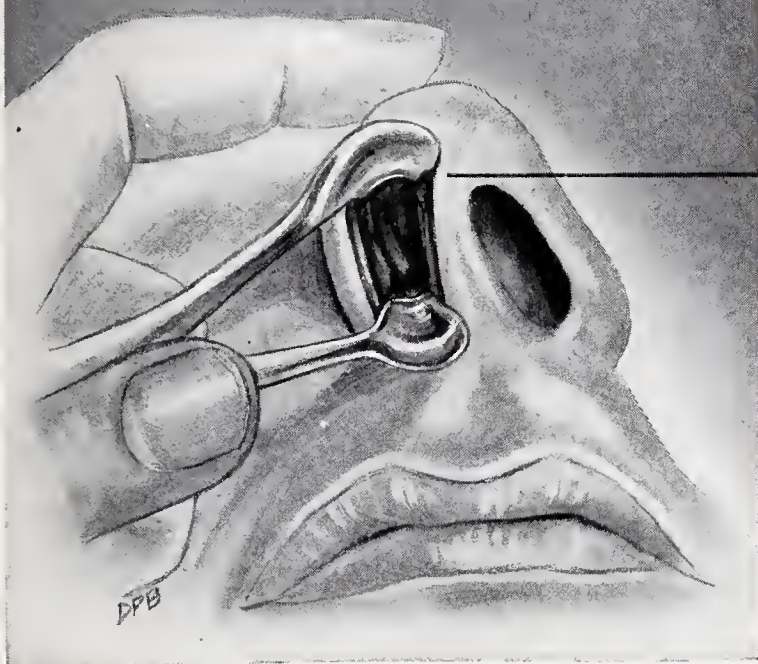
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REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there is always a program at the meeting and articles in the *Journal* to challenge that interest.

THE MEETING this year will be composed of thirty-two sessions of the twenty-one sections, two General Clinical Sessions and two conjoint meetings. Eligible members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of \$5.00 include the *Southern Medical Journal*, a journal that should be a "must" on every physician's reading list.

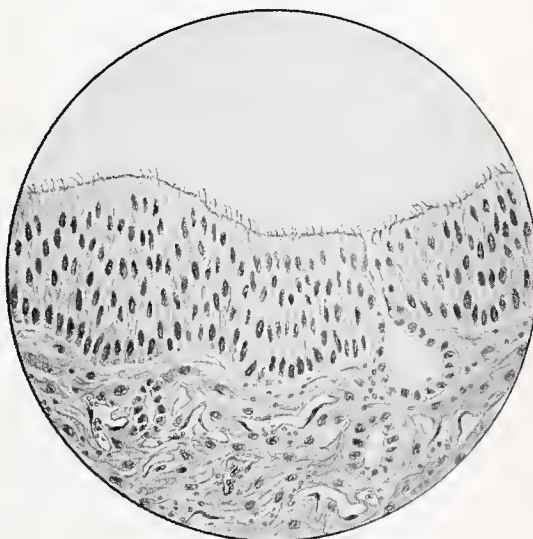
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porary County Health Nurse in giving inoculations against typhoid, diphtheria and small pox. Those attending were Mrs. Rushton, Mr. G. F. McLeod, Mrs. E. G. Burt, Mrs. J. H. Wilson, Mrs. Charles Weber, Mrs. John Ruff, Mrs. Paul Sizemore and Mrs. Evan G. Houston.

Mrs. Joe Rushton, President.

The Executive Board of the Woman's Auxiliary to the Arkansas Medical Society met on September 30 at the Hotel Marion, Little Rock, with Mrs. Louis K. Hundley presiding.

The following Nominating Committee was elected: Mrs. Mason G. Lawson, Mrs. Ralph Weddington, Mrs. J. B. Crawford, Mrs. Garland Murphy, Jr., and Mrs. C. W. Anderson.

Mrs. Hundley welcomed two newly organized Auxiliaries: Lawrence-Randolph-Sharp and Pope-Yell counties.

Mrs. Warren S. Riley announced the Membership Drive will begin October 1, and that the roster of paid members must be complete by November 1.

Mrs. Gordon P. Oates, Chairman of Exhibits,

reported that booths to distribute Anti-Socialized Medicine literature had been operated at Thirty County Fairs and two district shows. Booths are to be manned at the Horse Show in Pine Bluff, B. & P. W. Conference in Hot Springs and at the Arkansas Livestock Show in Little Rock. 500,000 pieces of literature are to be distributed at these fairs and shows.

Following the meeting and luncheon, Mr. Clovis Copeland, guest speaker, related the deplorable state of Medicine in Socialized England, as he observed it on his recent visit abroad.

Mrs. Howard S. Stern,
Recording Secretary.

WASHINGTON COUNTY

The Woman's Auxiliary to the Washington County Medical Society held their regular meeting in September. Ten members were present. The Secretary reported \$5 had been sent to the Student Loan Fund.

Mrs. P. L. Hathcock, Sec'y.

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No. 7

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No. 7

WIRE SUTURES—SURGICAL STATUS AND TECHNICAL ASPECTS*

GILBERT O. DEAN, M. D.
Little Rock

Since Babcock¹ described its usage in 1934, stainless steel wire (alloy 18-8:—chromium 18-20%; Nickel 8-10%, steel 70-74%) has become a reliable and inexpensive addition to the technical armamentarium of many surgeons. Tantalum wire^{2,3} has also proved to be useful and safe, but its cost is still prohibitive of general usage.

The present extensive usage of wire sutures is somewhat surprising in light of the poor results from earlier attempts² to use metal sutures and in light of the increased technical difficulties that the surgeon encounters in using wire as a suture material. Most surgeons using wire sutures will agree that the technic is slower and requires more attention to details than the use of catgut, silk, or cotton.

What, then, is the reason for the continued and increased usage of stainless steel and tantalum wire in surgery?

Advantages and Usage

The answer appears to be twofold: first, stainless steel wire,^{1,3,4,5} and tantalum wire^{2,6,7,8} cause little or no tissue reaction; second, in the presence of wound complications such as infection, hemorrhage, or necrosis, the wire sutures maintain a passive role and interfere in no way with secondary wound healing. Many surgeons using only catgut, silk, or cotton sutures have been appalled to see some of their surgical wounds become inadvertently infected and subsequently complicated by dehiscence, evisceration, and hernia formation. After adopting the wire technic some of these surgeons have been gratified to see similarly infected wounds hold their fascial

integrity and heal secondarily without dehiscence, evisceration, or hernia formation. Thomas Jones¹⁶ has reported a series of colon resections in which 33 per cent of the wounds became infected if closed with catgut alone, 17 per cent became infected if closed with catgut and stainless steel sutures, and one wound in 103 cases became infected when only stainless steel wire sutures were employed. The author has observed a drop in recurrence rate from incisional hernia repair of from 36 per cent to approximately 1 per cent when stainless steel wire was adopted as the suture material of choice.

Babcock¹ states that "the finer sizes (33 to 40 B and S gage) may be used for ligatures or delicate sutures for skin, mucous membrane, nerves and tendons, bladder, ureters, bile ducts, intestines, esophagus, and mouth. The medium sizes (30 to 32 B and S gage) for through and through and buried sutures, the larger sizes (14 to 28 B and S gage) to hold fractured bones. In the peritoneum wire sutures do not, like catgut, attract adhesions." Babcock prefers size 32 or 35 for closure of the peritoneum; sizes 32 and 30 for aponeurosis, size 35 for fat and muscle, interrupted 35 and continuous 38 for the skin, and sizes 36, 35, and 32 for ligatures.

Not many surgeons have adopted as varied a usage as Babcock and his colleagues have described. There is, however, a consensus that a skillful use of inert wire sutures is the technic of choice in the repair of incisional hernias, in the repair of actually or potentially infected wounds, and in the closure of sinus tracts from the bowel, bladder, stomach, ureter, pancreas, and biliary tract. The author, substantiated by his own experiences and that of many surgical colleagues throughout the United States, has repaired all types of hernias exclusively with stainless steel wire sutures since 1938. Many surgeons ligate all bleeders in their incisions with fine wire ties. Others close all abdominal incisions exclusively with wire, while others still prefer to use catgut as a continuous suture for closing the peritoneum and posterior fascial lay-

* Read before the Seventy-Third Annual Session, Arkansas Medical Society, Little Rock, April 14, 1949.

ers, and interrupted stainless steel wire sutures in the anterior fascial layers. Wire sutures of the same chemical consistency are also preferable for fixing or stabilizing metallic plates or gauze in the tissues.

All wire users agree that early ambulation is safer and that the average post-operative hospital stay is shortened when the wounds are closed with wire. The number of post-operative complications is also lessened.

The use of wire sutures, however, does not preclude the complications of wound dehiscence and evisceration (even in the absence of infection) if the surgeon neglects to utilize the necessary precaution of an adequate "through and through" wire closure (sizes 25 to 28) in debilitated and malnourished patients. The author has seen and continues to see an occasional wound dehiscence because the surgeon fails to evaluate the patient's nutritional deficiencies and wound healing propensities after operations for perforated peptic ulcer, gastric and intestinal carcinoma, chronic biliary tract disease with associated jaundice, and far-advanced intestinal obstruction.

Misconception and Dangers

Many misconceptions have arisen among physicians and the laity concerning the usage of wire sutures. One misconception that is often disturbing to the wire-using surgeon is that he has "gone overboard" in his enthusiasm and uses nothing but wire sutures and ligatures for all surgical procedures. Contrarily, the wire surgeon tends to be extremely cautious in his usage of wire and tends to use catgut, silk, or cotton, as often or more often than wire, because he knows there are many contraindications to the use of wire.

The misconception that wire sutures ionize, undergo electrolysis, liberate metals that form poisonous metallic salts in the tissues, and cause undue tissue necrosis and fibrosis is a vestige or carryover from the days of trial and error²⁹ with silver, aluminum, copper, and such alloys of dissimilar metals as bronze, German silver, brass, magnesium compounds, carbon steel, chrome steel, vanadium steel, nickel-plated steel, and many forms of stainless and rustless steel. It must be emphasized that only "18-8 or 18-8-smo stainless steel" and tantalum wire sutures are now considered acceptable to the wire surgeon. Vitallium is relatively non-irritating to tissues, but it is too brittle to be drawn into a useful surgical

wire. Other metals such as zirconium,¹⁴ tellurium, titanium, and wrought ticonium are relatively inert in the tissues, but as yet none of these have any definite advantage over the more ductile and less expensive 18-8 alloy steel.

It must also be emphasized that the wire suture material be kept clean and free from all contaminating substances such as rubber bands, instrument oils, etc. It is also important that the surgeon does not intentionally or inadvertently use more than one kind of metal or alloy suture in a wound. This latter error should be especially avoided when the surgeon uses metal sutures for fixing or reinforcing the stability of metallic plates or gauze in the tissues.

The misconception that the wire sutures may eventually migrate to vital structures has not been substantiated in any case where the surgeon has displayed sound judgment in his use and placement of sutures. Similarly, the idea that previously inserted wire sutures will interfere with the surgical technic of a subsequent operation in the same location has been disproved by those who have used the wire correctly.

The danger of medicolegal entanglements due to the usage of wire has not proved to be a serious deterrent to the advocates of wire sutures. Obviously, many possibilities for trouble of this nature do exist and the surgeon using wire sutures needs to evaluate the medical mores and prejudices of his locality before utilizing the wire technic to its full advantage.

The Surgeon's Technic

Two factors militate against the indiscriminate and careless use of wire sutures. The first factor is the possibility of a buried wire strand pricking the skin from the inside, or forming a skin prominence that is easily irritated by any or all contacts in that area. The use of wire sutures in an obese or well-padded individual can result in the above complication if he or she subsequently loses considerable weight and the panniculus adiposus disappears. The above possibility adds to the second factor, which is the necessity for a slower, more detailed and cautious technic in the use of wire sutures.

In order to avoid the skin irritation factor, the wire surgeon should use as small gage wire as is feasible. He needs to tie the suture knots carefully without kinking the wire and to pull down the second and third loops tightly in order to leave the knot small. He must cut the redundant strands of wire close to the knots. He should

avoid all unnecessary sutures in the subcutaneous fat. In closing the ordinary vertical rectus or transverse abdominal incisions, many surgeons purposely delete the subcutaneous wire sutures; and they believe that such wounds heal just as well, if not better, than those containing sutures in the fat.

The propensity for wire to cut the tissues necessitates against tying the first loop of the suture too tightly. Also, the tendency for the wire to cut tends to motivate the surgeon to include so much tissue in the suture that strangulation may ensue. Dulin¹⁶ has minimized the danger of wire cutting the tissues by pointing out the fact that some cutting of the tissues will prevent strangulation.

The Surgical Nurse's Technic

There are a number of technical difficulties in the usage of wire sutures that involve the time and efforts of the surgical nurses as well as the surgeon. The wire on the spool tends to unravel, loosen, and then become entangled if the free end is not carefully held after the needed strand is cut. Also, the strands that are prepared for suturing tend to retain the curvature of the spool, roll up, and to become entangled and kinked about one another. Each twisted and kinked strand of wire is then difficult to prepare for proper suturing. In addition, the repeated cutting of wire strands by the nurses and surgical assistants rapidly dulls the edges of two pairs of scissors.

A number of technical procedures and devices have been developed and utilized for the purpose of overcoming many of the above technical difficulties.

First: In order to free the operating nurse from repeated handling of the recalcitrant spool of wire, it is best to have prepared, sterilized, and held in readiness, an adequate number or a bundle of wire strands of the required gage and length. This step is accomplished by winding the needed amount and size of wire about the long axis of a 17-19 inch piece of flat metal, or "wire winder." The wire is then removed from the "winder" by cutting across all strands of wire at one end of the winder. All strands of wire must now be held taut to prevent kinking and entanglement. A rubberized hemostat is very useful in holding the loose cut ends of the wire bundle.

Second: Before cutting the other ends of the wire strands, it is best to slightly twist the uncut

ends and insert the entire bundle through a stainless steel metal tube, which is about 16 inches long and has an inside diameter of approximately one-fourth inch. After the wire bundle has been inserted through the tube, the uncut ends can be cut, and all ends trimmed with the scissors, thereby leaving both ends of all wire strands free, unbent, and unkinked. Several tubes containing wires of various needed sizes can be prepared and fixed to a bassboard splint for sterilization and storage. If strands of wire longer than 16-19 inches are desired, it is best to leave one end of the wire bundle untwisted and uncut after it is inserted through the tube. Then, by pulling out an uncut double length of wire from the uncut end of the bundle, a single strand of wire 32-38 inches in length becomes available.

Third: One of the most satisfactory and inexpensive types of scissors to use for cutting the wire strands and sutures is a pair of short-bladed dental gum shears, retail price, \$1.50. The short blades are of particular advantage in cutting the suture ends close to the knots. The author has two pairs of such shears that have been used for eight years.

A New Instrument—Wire Suture Dispenser

In order to further simplify the preparation, handling, storage, and operating room dispensing of the wire sutures, there has been developed a container and dispenser which is capable of holding and protecting at least four sizes of wire. The wire suture "dispenser" consists of four stainless steel metal tubes (16 inches long and with inside diameter of one-fourth inch) which are fixed to a flat metal plate in such a way that the plate extends one and one-half inches beyond the ends of the tubes and angles upward far enough to impinge against and lock in place protective sliders which fit in position over each end of the apparatus. The protective sliders can be moved inward and outward over the ends of the tubes for a distance of several inches. The sliders are to be retracted inward for the purposes of inserting or removing wire strands and are to be pulled outward and locked in position over the ends of the tubes for protecting the ends of the wires during the processes of sterilization, storage, and transportation to and from the operating rooms. With the protective sliders locked into position, the wire strands are completely protected from kinking, bending, and tangling of the ends. A felt clamp has been added to the apparatus to hold the

wire bundles in place while individual wires are extracted during an operative procedure.

Advantages of the container are that it obviates the usage of single tubes which tend to roll around and fall off the instrument tables, it lies flat and is stable in its position, it provides ready availability of at least four types or sizes of wire sutures, it can be easily cleaned, it is relatively non-destructible, and last, but not least, it is simple to operate.

If the operating room nurses will carefully select the sizes of wire needed, if they will use moderate care in preventing kinking of the wires while inserting them into the tubes, and if they will take care in not overfilling the tubes with wire and in replenishing the wire when it is depleted, the above described container can be utilized in deleting many of the technical difficulties that surgeons and operating room nurses encounter with the wire technic.

Conclusions and Summary

1. The use of wire sutures in surgery has become a permanent part of the technical armamentarium of many surgeons.

2. Alloy 18-8: Chromium 18-20%, nickel 8-10%, steel 70-74%, is the form of stainless steel wire that has proved least expensive and inert enough for safe general usage. It is useful and available in sizes ranging from 40 to 14 B and S gage.⁹

3. Tantalum wire is almost totally inert in the tissues and is fairly satisfactory as a suture material. Its cost is still too high to permit general usage. It is available in sizes ranging from 40 to 22 B and S gage.⁸

4. Other metals such as zirconium, tellurium, titanium, and wrought ticonium are inert and may be useful for surgical purposes, but their lack of ductibility and high cost are still prohibitive to general usage as suture materials. Vitallium, which is relatively inert in tissues, is too brittle to be utilized as suture material.

5. The use of wire sutures is definitely indicated in certain types of surgical procedures and the possible scope of its usage is wide. It has been proved that the rate of occurrence of many post-operative complications can be lowered with the proper employment of wire sutures.

6. Many misconceptions concerning the usage of wire sutures still persist.

7. The use of wire sutures does not obviate

the possibilities of post-operative complications, and there are several possible complications that may be due to unwise use of wire sutures.

8. The use of wire adds certain technical difficulties to the surgeon's and nurses' routine.

9. Methods for avoiding many of the complications and technical difficulties have been discussed.

10. Two new instruments for preparing, preserving, and dispensing wire sutures have been described.

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CONGRESSMEN VIEW ENGLAND'S MEDICAL CARE

The comments of those congressmen who recently visited England and Sweden to investigate medical care in those countries is most revealing. In a fast two weeks' trip members of the House Interstate and Foreign Commerce Committee had the opportunity to clarify and augment their thinking upon matters of national medical care in the United States. As described in "Washington Report on the Medical Sciences" the congressmen were disquieted by what they saw and heard abroad.

The sojourn abroad did not make converts for either side. Probably the best effect of the tour will be to increase the powers of discrimination of the congressmen regarding future medical legislation in the United States. If on future hearings on medical bills the congressmen will be better able to appraise some of the acrimonious arguments, the name calling, and the grim recitation of "alleged facts" for which there is no documented proof, then the trip will be highly beneficial for the future medical care of this nation.

Here is a summary of the statements of the congressmen who participated in the survey.

Beckworth, (D., Texas). You can't nationalize medicine and stop there. It leads to nationalization of other things. The visit was highly beneficial but I returned with my confidence unshaken in the American medical profession and the way we do things in this country.

Dolliver (R., Iowa). I am more than ever opposed to socialized medicine. I am thoroughly convinced that the British scheme is unworkable over here and it would lower professional and medical care standards. Aneurin Bevan (Minister of Health) is frankly out to extend socialism but, from a personal standpoint, he is a fellow one can't help liking.

Underwood (D., Ky.). The trip will serve to make me more conservative in making up my mind on action that should be taken. I never was for socialized medicine. But I still feel it is necessary for good health services to be made available to all of the people at reasonable rates of payment. I hope the medical profession will help achieve that goal.

Ellsworth (R., Ore.). What England and Sweden and other countries abroad are doing about their health care systems has no real application to the United States. Their present circumstances and historical backgrounds are both so different from ours that it would be completely

futile to make a translation into terms of desirable action over here. Nevertheless, we learned a great deal that will stand us in good stead when health legislation is under consideration.

Wilson (D., Okla.). The insight which I received into the administrative workings of the British and Swedish plans will be very valuable. But I still have reached no conclusions, except that Aneurin Bevan is a most energetic personality. The committee collected a great amount of information which will prove useful in discussions of pending legislation.

Biemiller (D., Wis.). Every doctor I talked to agreed they could practice better medicine than before; they could prescribe the medicines people really needed and know their patients could get them. Administrative costs are only 2.3 per cent under the present British plan, compared with 8 per cent for the best of our voluntary plans. Bevan went out of his way to point out the distinction between socialized medicine and health insurance. Dr. Charles Hill, secretary of the British Medical Association, was extremely critical of the AMA who, he claimed, had grossly misrepresented their insurance proposal by saying that the quality of medical care had deteriorated. Dr. Hill also emphatically stated his belief that voluntary health insurance plans could never meet health needs in Great Britain because they could not extend coverage to enough of the population. If you don't have a compulsory health insurance plan with adequate coverage, you walk right into socialized medicine. One bad feature of the British system is that it tries to cover the entire population and every aspect of medical and health care at the same time and there is lack of effective local control at many stages.

The Swedish health program is much more applicable to the United States than the British. Sweden's present system of voluntary health insurance, subsidized by the government, will be succeeded in 1951 by compulsory health insurance because voluntary plans just didn't work, even with large government subsidies. In the new scheme, each patient will pay one-fourth of all expenditures for medical care.

Glliette (R., Penna.). I am more opposed to socialized medicine now than I ever was before. It will bankrupt any country.

McGuire (D., Conn.). I saw nothing over there I would adopt over here. Bevan, he's the next prime minister, thinks the government can save money by manufacturing hearing aids so private manufacturers are going to be driven

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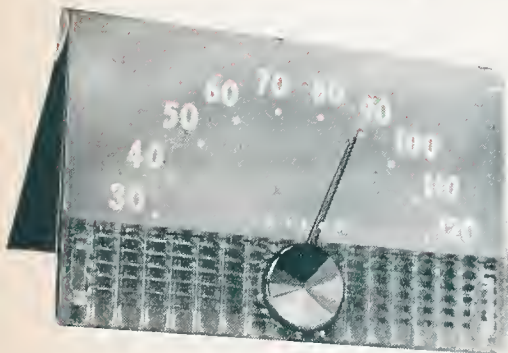
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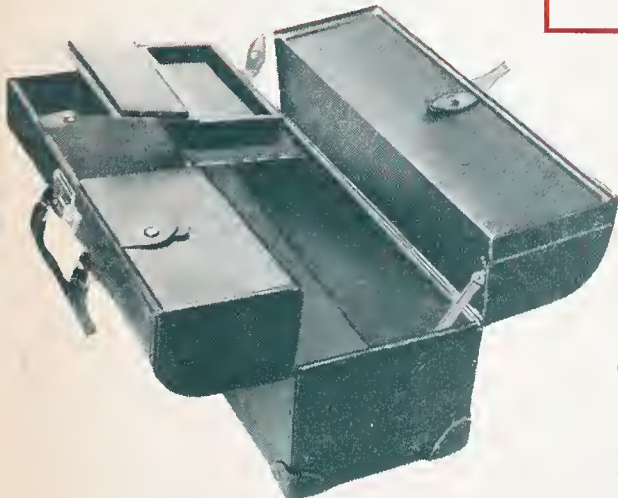
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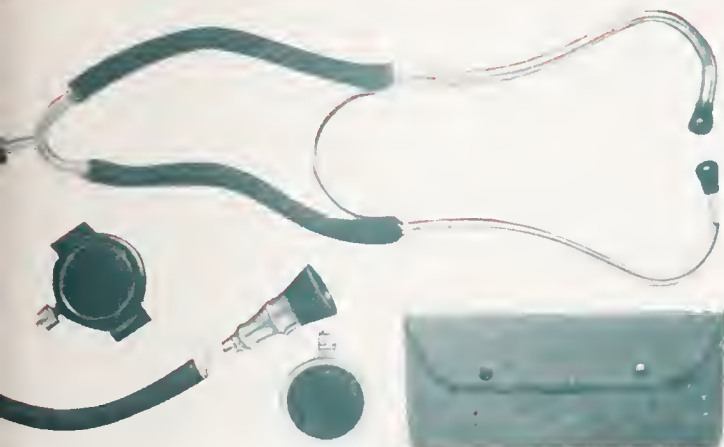
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ed---Merry Christmas and Happy New Year

out of business. As far as the doctors are concerned, though, they are doing better financially than they were before. I was amazed to learn that.

Bennett (R., Mich.). Some of the things I saw confirmed my previous thinking. Others had a contrary effect. British doctors seemed to be more reconciled to the system than I thought would be the case, though this may be due to fear of the consequences if they rebel. One point agreed upon by doctors whom I believe are impartial is that the country attempted too big a gulp at one time. To this Bevan says "no" but nevertheless it seems that the program has been swept away from its original objective of furnishing care for the medically indigent and the country has wound up with a complete system of state medicine. It is a purely socialistic scheme, based on the theory that the government can spend your money best.

Linehan (D., Ill.). Nationalized medicine isn't working over there and it won't work here. People seem to be afraid of Bevan. He's going to be the next prime minister if the Labor party stays in power.

O'Hara (R., Minn.). From what I saw, I would say that our indigent obtain far better medical care than do those of England and Sweden. The original ideas I had on this subject of providing health services were strengthened by the trip. The British, having jumped into something as big as this without possessing enough doctors and nurses, are having a hell of a time. The Swedish have been more cautious in their approach. As for bills now awaiting action by our committee, I will support those that will relieve the shortage of doctors and nurses but I am still opposed to the school health services bill in its present form—New York Medicine, Oct. 20, 1949.

CORRESPONDENCE

October 13, 1949

Dr. R. C. Dickinson,
Horatio, Arkansas.
Dear Doctor:

Democracy and socialism can never travel the same economic road, and to advocate socialism is to oppose democracy. Those favoring socialism do not care to compare the resources of this country and the welfare of its people with the resources and welfare of any other nation. Even though the United States is one of the youngest nations, our system of government has produced for its people more than all the other nations in the world combined. Why? Simply

because our economy is based upon individual initiative, free enterprise, and open competition. Every man, woman, and child is afforded the opportunity to visualize the possibilities of advancing and obtaining something more stable for himself, his family, and his future generations. But, in those socialistic countries where individual initiative is abolished and the government owns or controls everything, only the privileged few can look forward to a bright future—for the great majority know that their efforts are to be wasted in that the economic benefits will be equally divided between the energetic and the indolent.

We have been able to accomplish the unbelievable in this democracy merely because of the independent freedom of our people from government regimentation. Overnight preparations for the fighting of the last two world wars by a freedom-loving people, unprepared for war against war-minded nations that had been preparing for decades to abolish democracy, is ample proof of the necessity for individual incentive.

Our medical profession has systematically abolished diseases which encroach upon humanity. No longer do our people fear the once-dreaded smallpox and typhoid fever, for example. All know that in due time polio will be understood and more effectively controlled. This assurance is due to the individual initiative afforded the members of our medical profession. Each doctor can visualize the possibilities of not only being helpful to humanity; but the possibilities of bettering the economical standards of himself, his family, neighborhood, and government.

I was in the Army long enough to know that when a doctor works by the clock and waits for pay—as would be the case under socialized medicine—that the incapacitated may expect the same dose of medicine for hydrophobia or a bad cold. Socialized medicine will amount to just one more step toward the socialization of a great democracy, the abolition of freedom, and the deterioration of an outstanding government of the people, by the people, and for the people.

Therefore, you may be assured that I shall oppose any legislation seeking a regimentation of our people with their doctors. I have always felt that to preclude individual initiative, free enterprise, and open competition will, in effect, abolish the very prerequisites of a democracy.

Yours sincerely,

Boyd Tackett.

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EDITORIAL

A ONE-SENTENCE EDITORIAL

No country that has adopted compulsory sickness insurance taxation has kept its promises.

SO WE GAVE HIM PENICILLIN

Reprinted from New York State
Journal of Medicine

For many years we have been saddened by seeing medicine outreach itself. About fifty years ago, all congenital dislocations of the hip were to be cured by Dr. Lorenz's bloodless method. The millionaire's daughter that he was brought here to cure, with tremendous fanfare of newspaper publicity, is still as badly off as she ever was. Next we had 606. One injection, and syphilis had lost its terrors. That wasn't quite true, either. Then two men from Australia arrived to tell us how to cure cases of spastic cerebral paralysis by operations on the sympathetic nervous system. Hunter is dead. Where Royle is we don't know.

The sulfa drugs invaded us. A wonderful advance, to be sure, but what about their crystal-

lization in the kidneys, suppression of urine, and other complications?

Then came penicillin. The antibiotic, the underground warrior against bacteria. Suppose you can't make an immediate diagnosis, shoot the patient full of penicillin, and nine times out of ten you'll cure him. Perhaps. But what happens in the one case that you don't? We quote from a summary of a recent article.*

"Symptoms were markedly altered by chemotherapy (for this we think should be read the combination of sulfa drugs and penicillin) in the following conditions: (1) diverticulitis with cancer; (2) fibrosarcoma, (3) perinephritic abscess, (4) lung abscess, (5) acute cholecystitis, (6) subphrenic and subhepatic abscess, (7) mastoiditis (8) empyema, and (9) osteomyelitis."

The patient enters the hospital, evidently sick and with an alarming fever. Well, of course, on a cursory examination, you can't make an exact diagnosis. The attending surgeon can't be reached, so what can the House Officer or Resident do? Why, give him penicillin, of course. Not an overwhelming dose, naturally, because he doesn't dare to, until the diagnosis has been made, but just enough to keep the temperature down and the bugs quiet, until the allwise attending or the still more unfortunate consultant comes along. How can either of them possibly make a diagnosis? The temperature is down, the bacilli are hibernating. All signs of danger are masked.

Finally someone says, "How long is this patient going to stay here? No temperature. No physical signs. Discharge him."

Then, the penicillin having been stopped, he comes back; sick all over again. And with the masked, and the virulence of the bacteria lessened. But they are still virulent. And they eventually break out. And when they do, penicillin is much less effective than it might have been, because it has already been used as birdshot instead of buckshot.

It is too much to ask of our ultra scientific hospitals that they make at least an attempt at diagnosis before they mask every presenting symptom by flooding the patient with an antibiotic? It is too much to ask that the medical profession should not again be swept under by one of the tidal waves we have already outlined?

Doctors made diagnoses before they had the X-ray, the Wassermann reaction, the electrocardiogram. They used their five senses and they used to think. Remember?

*J.A.M.A. 138:645 (October 30) 1948.

THE 1950 MEMBERSHIP ASSESSMENT

Members and county society secretaries are reminded that the 1950 membership assessment due from members on January 1st, 1950, has been placed at twenty dollars by action of the House of Delegates at the 1949 annual session. Increasing activities of the Society require additional funds. It is hoped that prompt remittance of the assessment will be made by all members, facilitating the work of the Society.

THE 1950 SESSION

The 1950 annual session of the Society will be held at the Goldman Hotel, Fort Smith, April 17th, 18th and 19th. Early hotel reservations are suggested. Headquarters for the Woman's Auxiliary to the Arkansas Medical Society will be at the Ward Hotel.

RANDOM THOUGHTS OF THE SECRETARY

October 16th. Briefly visiting Boise and departing its tree-shaded streets which will give our French-speaking readers the origin of the city's name, we travel across rounded hills with their dense sage and bitter brush to enter the Payette National Forest, establishing ourselves at the base camp and endeavoring to acclimatize to the 32-degree temperature, poorly effected especially as night comes with a greater drop and the sleeping bag which Ben Pride recommended so highly must have been the one he used in Florida.

October 17th. Would Everett Foster have liked seeing us aboard a horse, the first time since he took Foltz with us across Yell County one Sunday afternoon as we strike out 12 miles for our camp in the woods, during the latter part of the ride wondering why anything so stuffed with hay should be so hard and why a saddle can get so sore.

October 19th. With the days becoming versed in nature as it reveals itself in these gorgeous woods learning the tracks of the elk, the deer, the bear, the cougar and others, observing the jays, the camp robbers, the robins and ever admiring the majestic firs and lodge pole pines which reach out to the intensely blue sky above with its fleecy cumulus clouds; snow, large dry flakes, adds to the beauty of this day in the wilderness and a new feeling comes to city folk as they ride among the trees, over deadfalls with snow flakes and cold winds striking tender faces, but it's great!

October 21st. Game remaining elusive although "sign" is plentiful, we shift camp to the Middle Fork of the Salmon River, even more rugged country, unhesitatingly termed by us the most beautiful mountain stream we have seen and the site of that fantastic nature story, the salmon spawning. Now each night lulled to sleep by the roar of the tempestuous stream as it dashes onward to the Columbia and to the Pacific.

October 23rd. Far down the river canyon today to find our travel evidence of the life of prospectors who have sought fortune here in these rocky canyons, eventually striking off for greener fields across the canyon but

for one whose last resting place is marked by a crude cross carved in the bark of a nearby pine tree and marveling at this breed of man who lived a life of loneliness and hardship in their quest of gold always at the end of the rainbow.

October 24th. As we ride the 16 miles back to main camp this morning, Bill, junior, sums it up, saying: "Just think, Dad, in a few hours we can sit in a chair which has a back to lean against." To which we add a conclusion: Primitive areas are for primitive people! The ride this morning highlighted by seeing an ivory-billed woodpecker, an almost extinct species, and most any bird-lover would take the trip for this experience alone. So ending the trip with cleaning and packing up, reading our first newspaper for eight days to learn of the football upsets last Saturday and that the MOP strike is over. Boarding the Union Pacific which takes us back to the "tenderfoot East" from which we came.

October 27th. Back to the accustomed routine with talks of near conquests and of experiences to afford conversation for many a day and with a photograph of the Continental Divide for Amis who feared the altitude for us.

October 29th. To Homecoming with all its color and festivity, to which the game contributes in small degree.

October 30th. Attending the wonderfully staged and customized "Ice Cycles" at Tulsa, ever entertainment of excellence.

November 5th. Holidaying with Peggy in New Orleans to witness the exciting Tulane-Navy tussle, not quite up to the predictions of Grantland Rice and Brooksher made last June but nevertheless, a thrilling contest. Wandering about the Vieux Carre in the evening, finding that we can have most success in obtaining a table from Albert at La Louisianne, where shrimp Remoulade and pompano en grille deserve as great accolades as are given to other French quarter specialties.

November 12. Toastmastering the first annual banquet session of the Arkansas Society of X-ray Technicians, a gala affair.

November 13th. Joe Lawrence talks with earnestness of the work of the Washington office to the Council today bringing a realization to us of the immensity of the job handled by this capable specialist in the field of medical legislation. Returning by Braniff homeward, our first flight since that distress-attended flight of September 30th: this one routine.

OBITUARY

CLEO CLEVELAND BALL, age 70, died at his home in Ravenden November 4th of a heart attack. A graduate of Washington University School of Medicine in 1904, he had practiced at Ravenden for the past 45 years. He had served in the various offices of the Lawrence County Medical Society and was formerly a member of the County Board of Education and of the Democratic Central Committee. Surviving are two sons, two brothers and one sister.

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PUBLIC RELATIONS

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Advisors to the Chairman—D. A. Rhinehart,
Little Rock; R. B. Robins, Camden; Joe F.
Shuffield, Little Rock.

1. LIAISON WITH THE AUXILIARY—Louis K. Hundley,
Chairman, Pine Bluff; Charles R. Henry, Little Rock;
Joe Verser, Harrisburg.
2. EXTENSION OF MEDICAL CARE — George Stein-
kamp, Chairman, Little Rock; G. R. Siegel, Clarksville;
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Ferguson, Nashville; Frank Kumpuris, Little Rock; H. J.
Mayfield, El Dorado.
3. PRESS—(To Be Appointed Later.)
4. RURAL HEALTH—Joe W. Reid, Chairman, Arkadel-
phia; John C. Faris, Jonesboro; Henry Hearnberger,
Stephens; B. M. Gardner, Star City; B. N. Saltzman,
Mountain Home.

MEDICAL EDUCATION AND HOSPITALS

Roy I. Millard, Chairman, Russellville. Advisors to the Chairman—H. T. Smith, McGehee; A. S. Buchanan, Prescott.

1. POST GRADUATE STUDY—A. D. Garner, Chairman, Paragould; Jeff Banks, Little Rock; E. J. Stroud, Jonesboro; D. A. Rhinehart, Little Rock; M. D. McClain, Little Rock.
2. CANCER CONTROL—Henry Hollenberg, Chairman, Little Rock; Carl Rosenbaum, Little Rock; Fred Hames, Pine Bluff; Fred Krock, Fort Smith; L. P. Good, Texarkana; Glenn H. Johnson, Little Rock; R. H. Willett, Jonesboro.
3. TUBERCULOSIS COMMITTEE.—Harvey Shipp, Chairman, Little Rock; R. E. McLochlin, Little Rock; John Gruetter, Little Rock; J. D. Riley, State Sanatorium.
4. MATERNAL WELFARE—I. F. Jones, Chairman, Fort Smith; Willis E. Brown, Little Rock; T. T. Ross, Little Rock; William B. Harrell, Texarkana; Clyde D. Rodgers, Little Rock; B. J. Reaves, Little Rock; Hoyt Choate, Little Rock.
5. CHILD WELFARE—John T. Gray, Chairman, Little Rock; B. P. Briggs, Little Rock; Sam Phillips, Little Rock; T. T. Ross, Little Rock; John W. Smith, Little Rock; R. E. Rowen, Little Rock; William A. Reilly, Little Rock.
6. LIAISON WITH THE STATE HEALTH DEPARTMENT—W. B. Grayson, Chairman, Little Rock; Julius Helums, Dumas; Van C. Binns, Monticello; J. P. Bremer, Point Cedar; W. F. Barrier, Malvern.
7. LIAISON WITH THE STATE HOSPITAL FOR NERVOUS DISORDERS—R. V. McCray, Chairman, Malvern; W. J. Ketz, Batesville; A. R. Russell, Pine Bluff.
8. LIAISON WITH THE STATE MEDICAL BOARD OF THE ARKANSAS MEDICAL SOCIETY—Robert Hood, Chairman, Russellville; S. W. Chambers, Mountain Home; Fred Ogden, Fayetteville.
9. HOSPITAL RELATIONS—A. S. Koenig, Chairman, Fort Smith; T. P. Foltz, Fort Smith; George Burton, El Dorado; F. W. Harris, Little Rock; F. S. Dozier, Marianna; M. D. Prickett, Little Rock.
10. MEDICAL EDUCATION—James M. Kolb, Chairman, Clarksville; C. C. Long, Ozark; J. W. Amis, Fort Smith; G. W. Reagan, Little Rock; H. W. Thomas, Dermott; A. F. Hoge, Fort Smith; G. D. Murphy, Jr., El Dorado.

THE STATE MEDICAL BOARD OF THE ARKANSAS MEDICAL SOCIETY

C. Ray Williams, Morrilton (1951).
 L. J. Kosminsky, Texarkana (1951).
 Joe Verser, Harrisburg (1951).
 H. J. Hall, Clinton (1953).
 Charles Lutterloh, Hot Springs (1953).
 G. D. Murphy, Jr., El Dorado (1953).
 M. L. Harris, Newport (1953).

ARKANSAS STATE BOARD OF HEALTH

E. D. McKnight, Brinkley (1950).
 Chas. A. Archer, DeQueen (1950).
 J. P. Price, Jr., Monticello (1951).
 J. G. Gladden, Harrison (1951).
 M. E. McCaskill, Little Rock (1952).
 Thomas Wilson, Wynne (1952).
 A. S. Buchanan, Prescott (1952).
 Don Hamm, D.D.S., Clarksville (1953).
 C. J. Wright, Ph.G., Russellville (1953).

ARKANSAS BASIC SCIENCE BOARD

Louis Gebauer, Little Rock (1953).
 S. C. Dellinger, Fayetteville (1950).

E. A. Provine, Arkadelphia (1951).
 Chas. V. Robinette, Conway (1952).

ARKANSAS STATE CANCER COMMISSION

Hon. Sid McMath, Little Rock (ex-officio).
 Henry Hollenberg, Little Rock (ex-officio).
 W. R. Brooksher, Fort Smith (1953).
 Carl A. Rosenbaum, Little Rock (1950).
 Mrs. R. C. Dickinson, Horatio (1952).

CORRESPONDENCE

Dear Dr. Brooksher:

The Board of Control and the staff of the State Hospital are interested in improving the treatment of patients referred to the State Hospital by physicians throughout the state. Due to the overcrowded condition of the State Hospital and the limited personnel available, it is necessary that some changes be made in the policy of visiting hours, and hours of admission of patients.

A central admission section is being provided in the hospital to be staffed by one physician, a registrar, social service workers, and collection officer. This will make possible the obtaining of necessary data on patients being admitted; proper examination of the patient at the time of admission, and the instituting of proper treatment soon after the admission of the patient.

The Board of Control at the last regular monthly meeting approved the hours of 8:00 a. m. to 4:00 p. m. as hours for cases to be accepted. The visiting hours will be 1:00 p. m. to 4:00 p. m. each day. I am sure the doctors in the state will gladly cooperate with us and they can be of great assistance in passing this information on to the relatives of patients, or to people who have members of their family to be admitted to the hospital.

It will be appreciated if a notice can be placed in the State Medical Journal notifying the physicians of the changes and requesting their assistance.

We want to carry out a treatment program for the mentally ill that will meet the high standards of the medical profession of the state, and hope that each physician will take an active interest in the State Hospital; will visit the hospital, and give us their suggestions on policies and treatment procedures which will improve the care and treatment of the patients.

Thanking you for your assistance and with kindest personal regards, I am

Sincerely yours,

George W. Jackson, M. D.
 Superintendent.

CONGRESSMAN OREN HARRIS BEFORE UNION COUNTY MEDICAL ASSOCIATION EXECUTIVE COMMITTEE, EL DORADO, ARKANSAS

"This Congress will not adopt the proposed National Health Insurance plan, the administration's program to socialize medicine," Congressman Oren Harris of El Dorado, Arkansas, recently told the Union County Medical Association Executive Committee.

The congressman, a high ranking member of the Committee on Interstate and Foreign Commerce in the House of Representatives, which has this legislation pending before it, said he did not believe such a program would be the best way to improve the nation's health. He said he did not believe the people were in favor of abandoning the most successful health program ever provided in any nation for the socialized method and neither did he consider in any way that there was a mandate from the people to provide such a program.

"Though we have had marked improvement, I believe there is still a real need for improved health services. I violently disagree with the viewpoint that the federal government through its domination and control can better provide this need than our voluntary method and free exercise of judgment as prevails."

"I object to such a departure, not only because I do not believe socializing the medical profession is the best way toward improving the health of the nation, but it would further extend the domination and control of our economy and the lives of our people by the federal government," said the congressman.

Complimenting the medical profession for its untiring efforts to improve the health of our people, he called attention to the fact that in 1900 life expectancy at birth was 49 years, and it has progressively increased and expects to reach 68 years this year, 1949.

The medical profession has shown, actually proving what can be done by their active participation and collaboration in developing sound practices and health programs since 1900 or before.

With reference to the investigation being made by the Department of Justice of the American Medical Association and various state organizations, the congressman said he did not agree at all with this method wherein threats and intimidation may result in order to reduce opposition to a legislative program. "Certainly such an investigation is untimely and cannot have any other implications than the promotion

of this national health program, minimizing organized opposition from the medical profession," he said.

"The Medical Association has shown a splendid attitude which should and will have far reaching influence on the general public by voluntarily opening up its records to the Justice Department and inviting them to come and see that their opposition is sincere and real and that they have nothing to cover up. Though resenting this method, it is the kind of cooperation characteristic of the medical associations.

"You doctors have a right to challenge a program of socialized medicine. You have a right to make a contribution toward honest organized effort just as business, labor organizations, and others in the country have and are doing. It is an expression of free speech which is guaranteed by the Constitution in your right of petition.

"The hospital construction program, which I helped to write as a member of the committee in 1946, and the expansion we provided this year is deserving the highest commendation in the promotion of better health facilities. The voluntary, charitable, and cooperative programs are the best ways through scientific efforts of our doctors to combat disease, bad health and giving our people the best possible health opportunities.

"I can only encourage you to keep up this fight and to give the members of Congress the continued cooperation and help, not only in opposition to the socialization program but in support of those programs that will provide a real need."

"I know what the proponents are doing and there are certain organized groups in the nation that are actively working for these socialized plans which have proven wholly unsuccessful."

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Literature available to physicians on request. MEAD JOHNSON & COMPANY, Evansville, Indiana, U.S.A.

PROCEEDINGS OF SOCIETIES

Prairie County Medical Society met in DeValls Bluff on October 20th, electing the following officers for 1950: President, Travis Matthews, Hazen; President-Elect, W. M. Parker, DeValls Bluff; Secretary-Treasurer, J. C. Gilliam, Des Arc; Delegate, J. C. Gilliam, Des Arc; Alternate, Roy Hill, Jr., Des Arc.

Ouachita County Medical Society met in Camden on November 3rd with the following scientific program: "Painful Shoulder," Samuel B. Thompson, Little Rock, and "Malignancy of the Larynx," Jack Brizzolara, Little Rock.

The Pulaski County Medical Society was addressed November 7th by Carl Moore, Saint Louis, on "Recent Advances in the Treatment of Blood Diseases." E. J. Easley, Secretary.

The Sebastian County Medical Society was addressed November 8th by Carl L. Wilson, "Urological Pitfalls for the General Surgeon." J. B. Stewart, Secretary.

The Arkansas Heart Association met at Little Rock November 3rd for the following program: "Diagnosis and Treatment of Acute Rheumatic Fever," B. P. Briggs; "Coronary Artery Disease," S. C. Fulmer; "Congenital Heart Disease," Don W. Chapman, Houston; and "Surgery of Congenital Heart Disease," Henry G. Hollenberg. A banquet session concluded the meeting.

The First Councilor District Medical Society met at Paragould November 8th for the following program: "The Diagnosis, Morphology and Treatment of Tumors of the Larynx," James B. Costen, St. Louis; "The Meaning and Management of Generalized Edema," Thomas Finley, New Orleans; "Bronchiogenic Carcinoma," Alton Ochsner, New Orleans. The evening public meeting was addressed by Dr. Matt L. Ellis, President, Hendrix College.

The Fifth Councilor District Medical Society met at Camden October 24th for the following program: "Meningitis in Infancy," James G. Hughes, Memphis; "Extrauterine Pregnancy and the Rh Factor," Henry B. Turner, Memphis; "New Ideas in Surgery of Interest to the General Practitioner," R. L. Sanders, and address, Euclid M. Smith, Hot Springs National Park. The evening banquet session was addressed by Allen A. Stockdale, New York, and Senator J. W. Fulbright.

PERSONALS AND NEWS ITEMS

Joe A. Norton, El Dorado, has passed his examination as a diplomate of the American Board of Radiology in radiology.

The following received fellowships in the American College of Surgeons at the recent Chicago convocation: J. Leo Aday, Little Rock; R. W. Blackford, Russellville; Eva F. Dodge, Little Rock; Ellis Gardner, Russellville; James H. Growdon, Little Rock; S. W. Hawkins, Fort Smith; Roy I. Millard, Russellville; Howard Schwander, Little Rock, and M. S. Wassell, North Little Rock.

Carl L. Wilson, Fort Smith, attended the American Urological Association meeting at Colorado Springs during October.

J. W. Kennedy is erecting a clinic building at Arkadelphia.

Louis K. Hundley, Pine Bluff; Edgar J. Easley and Frances C. Rothert, Little Rock, attended the Second National Conference of Physicians and Schools at Highland Park, Illinois, October 13th-15th.

Mahlon D. Prickett, Little Rock, addressed the annual meeting of the Arkansas State Nurses' Association in Texarkana on November 3rd.

Robert Watson, Little Rock, addressed the recent meeting of the Neurosurgical Society of America at Chateau Frontenac, Quebec, on "Subdural Empyema."

Robert Jones, Little Rock, and Fred Hames, Pine Bluff, conducted a diagnostic cancer clinic at Conway November 9th under the sponsorship of the Faulkner County Medical Society and the Faulkner County Division, Arkansas Cancer Society.

Earle H. Hunt, Clarksville, addressed the Tenth Councilor District Medical Society (Oklahoma) at McAlester October 21st on medical legislative trends.

S. A. Drennen, Stuttgart, contributed the chapter on "Arkansas" in "Wildfowling in the Mississippi Flyway."

I. F. Jones, Fort Smith, and Chas. R. Henry and Glenn Johnson, Little Rock, attended the recent session of the Central Association of

Obstetricians and Gynecologists at Oklahoma City.

A. A. Blair, Fort Smith, has been re-elected president of the Sebastian County Tuberculosis Association.

W. F. Adams, Fort Smith, attended the post-graduate course on obstetrics and gynecology at the University of Kansas during November.

H. J. Hall, Clinton, has been appointed a member of The State Medical Board of the Arkansas Medical Society to succeed the late W. H. Poynor.

In error, the September issue of The Journal reported the election of Charles Kennedy as surgeon of the Smackover post of the American Legion. W. L. Newton was elected to this position.

Dr. and Mrs. J. B. Ivy, Tuckerman, spent a recent vacation in the Rio Grande valley.

Dr. and Mrs. W. B. Gould, Glenwood, celebrated their golden wedding anniversary recently.

George W. Jackson addressed the Little Rock Community Council November 14th on "The Mental Health Program in Arkansas."

W. G. Cooper, Little Rock, and Fred Hames, Pine Bluff, conducted a diagnostic cancer clinic at Mountain Home November 11th under the auspices of the Arkansas Division, American Cancer Society.

Louis McFarland has been elected surgeon of the Hampton post, American Legion.

Carl A. Rosenbaum, Little Rock, recently took special work in vascular surgery in New York City.

Drs. Rodger and R. B. Dickinson, in association with their father, R. C. Dickinson, have opened a 20-bed hospital and clinic at DeQueen.

E. L. Dunaway, Conway, was recently elected to membership on the Conway Public School Board.

George Harrod, Conway, was presented the "Fifty Year Club" award at a special meeting of the Faulkner County Medical Society on

October 19th.

Alan G. Cazort and J. S. Levy, Little Rock, will move into their new office building at 1425 West 7th street during December.

Woodrow Lamb has been elected a director of the Paragould Booster Club.

BORN—To Dr. and Mrs. John W. Unruh, Little Rock, a daughter, Rebecca Ruth, on October 13th.

F. J. Scully, Hot Springs National Park, has been elected to the 33rd degree, Scottish Rite Masons.

J. J. Monfort, Batesville, took special work in surgery at Cook County Hospital, Chicago, during October.

Henry Carney, Texarkana, has been elected Arkansas chairman for the Southern Eye Bank.

Alan G. Cazort, Little Rock, served as instructor in a graduate course in allergy at Baylor University recently.

PIONEER DOCTOR OF MONROE COUNTY*

DR. WILLIAM LELAND WILLIAMSON

Dr. William Leland Williamson was born July 26, 1843, near Boltons ville, York District, South Carolina. His father's family moved to Mississippi in 1884.

He attended the University of Virginia, obtained his medical degree from a college in Baltimore, Maryland.

He served in the ranks of the Civil War, having joined a company of young men from Sardis, Mississippi, and was with Robert E. Lee's army in Virginia.

He married Miss Emma Octavia Moon in Oakland, Mississippi. Their only child was Octavas Lamar Williamson who studied medicine. Mrs. Williamson died soon after the birth of their son.

In 1878, Dr. W. L. Williamson moved from Mississippi to Moro, Lee County, Arkansas, practicing medicine there until 1902 when he moved to Marianna, Lee County, Arkansas, and was associated with his son, Dr. O. L. Williamson, until his death May 28, 1902. He was buried in Sardis, Mississippi.

* Presented by the Biography Committee, Woman's Auxiliary to the Arkansas Medical Society, Mrs. Chas. W. Dixon, Gould, and Mrs. C. W. Garrison, Little Rock.

PIONEER DOCTOR OF SEVIER COUNTY*

DR. JOHN WILSON HAMMONDS

Born—1831, near Bowling Green, Kentucky; died in 1914 at Chapel Hill.

He received his medical degree from the University Medical College, Nashville, Tennessee; was surgeon during the Civil War under General Morgan. He came to Arkansas in 1867, locating at Chapel Hill. Later he married Laura Hankins, raising a family of seven children.

He was in active practice until a few years before his death. In the early days he was a member of Sevier County Medical License Board. I have heard him state that there was only one other graduate M.D. in the county in 1867, who was located at Lockesburg.

He always responded to the call of the sick when possible, and never asked the patient or family if they were able to pay.

* Presented by the Biography Committee, Woman's Auxiliary to the Arkansas Medical Society, Mrs. Chas. W. Dixon, Gould, and Mrs. C. W. Garrison, Little Rock.

PIONEER DOCTOR OF MONROE COUNTY*

DR. LEWIS BYRUM MITCHELL

Born February 6, 1828, in Monroe County, Kentucky. Came to Austin, Lonoke County, Arkansas, about 1860 and practiced medicine until he enlisted in Civil War, March 17, 1862, as a Private—Regiment 25th Brigade Churchill. Was promoted to Assistant Surgeon, and discharged 1865. Was married to Sarah Jane St. Clair November 22, 1865. Nine children, six boys and three girls. He attended school in Louisville, Kentucky, and graduated in medicine in Nashville, Tennessee. Moved from Austin, Arkansas, to Brinkley, Arkansas, in 1888, and practiced until his death on November 7, 1906. Was buried in Brinkley, Monroe County, Arkansas.

By Mrs. E. D. McKnight, Brinkley, Arkansas. Compiled, 1948.

WOMAN'S AUXILIARY NEWS

The Hempstead County Medical Auxiliary met in the home of Mrs. Don Smith on Tuesday, October 11, at 10:30 A. M. The meeting was presided over by Mrs. Jim Martindale, president, who opened the meeting with a prayer. The Constitution and By-Laws adopted in May, was read by Mrs. Martindale and accepted. Mrs. W. L. Sims, Hygeia chairman, read an article

promoting subscription for Hygeia. She asked the cooperation of each member in getting subscribers by January 1st. Each member is to be responsible for literature against Socialized Medicine to be placed in all business places, clubs, schools and other organizations. All members agreed to cooperate in sponsoring the Essay Contest in the Hope High School, the topic being "Why the Private Practice of Medicine Furnishes America with the Finest Medical Care." Eligible members were discussed and dues collected for the year.

Mrs. Geo. H. Wright,
Publicity Chariman.

The Woman's Auxiliary to the Garland County Medical Society met on October 17, 1949, with Mrs. Floyd Clardy, hostess, and Mrs. Jack Wright and Mrs. E. K. Clardy, co-hostesses. Mrs. Leeman King presided over the business meeting. She gave an interesting report on the Arkansas Medical Auxiliary Board meeting in Little Rock. A report was made on the booth distributing literature on Socialized Medicine at the Business and Professional Women's Nine-State Conference, held at the Arlington Hotel, October 7-8-9. Also a report on the booth at the Garland County Fair. Plans were further discussed for the Benefit Bridge to be given at the Majestic Hotel, October 21, 1949. The proceeds to be used for the Garland County Convalescent Home. The next meeting will be held November 21st.

Mrs. L. E. Reed,
Publicity Chairman.

The Southeast Arkansas Medical Auxiliary met in Dermott, September 19th. After dinner with the doctors the ladies went to the home of Mrs. Brian Barlow, president of the Auxiliary. There were 16 members present. Mrs. H. T. Smith, State Physical Health Chairman, asked that members report on their health check-up and physicals. Plans were discussed for the distribution of Socialized Medicine leaflets during the Chicot County Fair. The following chairmen were appointed: Hygeia—Mrs. Walter Easterling; Physical Health—Mrs. H. T. Smith; Bulletin—Mrs. B. Z. Binns; Membership—Mrs. Lewis Hyatt.

Mrs. Van C. Binns,
Publicity Chairman.

Mrs. Harry Hayes, new president, presided at the first luncheon and business session of the Women's Auxiliary to Pulaski County Medical Society, on Wednesday, October 19, 1949, at



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*Werner, A. A.: The Climacteric in Women and Men, Postgrad. Med. 4:102 (Aug.) 1948.



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RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

noon, at the Junior League House. Hostesses were: Mrs. Lamar McMillin, chairman; Mrs. James L. Smith, Mrs. John Laman, Mrs. L. F. Barrier, Mrs. Ross Bizzell and Mrs. Henry Holtenberg. Mrs. C. E. Witt gave the invocation. Mrs. T. D. Brown introduced our speaker, Mrs. Louis K. Hundley, state president of the Women's Auxiliary to the Arkansas State Medical Society, who talked on "Public Relations."

The Howard-Pike County Medical Auxiliary met November 7, 1949, at the Howard County Memorial Hospital for their regular meeting. Mrs. F. F. Ferguson was appointed chairman of the "Doctor Day" Committee, and plans were discussed. Informal discussion was had on plans for other activities for the year. Fourteen members and four associate members were present. Mrs. H. H. Holt, President.

JEFFERSON COUNTY

Jefferson County Medical Auxiliary met October 7, 1949, for their monthly luncheon meeting, with eighteen members present.

Due to the Forum meeting, held October 6, the Auxiliary voted not to have the Public Relations meeting scheduled for November. The members feeling, that after such a successful forum on Compulsory Health Plan, that any immediate follow-up would not be necessary at this time.

Subscriptions were taken for Hygeia and the Bulletin. Reports of the fall board meeting were given, and work books were given to each member.

Mrs. R. E. Maynard, Sec'y.

BOOK REVIEW

The American Illustrated Medical Dictionary—A complete dictionary of the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Nursing, Veterinary Science, Biology, Medical Biography, etc.; with Pronunciation, Derivation and Definition. By W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lieut. Col., M.R.C., U. S. Army; Member Committee on Nomenclature and Classification of Diseases of the A.M.A.; Editor of "American Pocket Medical Dictionary." 21st Edition. 1,660 pages; with 880 illustrations, including 233 portraits. With the Collaboration of E. C. L. Miller, M.D., Medical College of Virginia. Philadelphia and London: W. B. Saunders Company, 1947. Price \$8 Without Thumb Index; \$8.50 with the Thumb Index.

This new edition continues the tradition of this excellent volume. The newer words and terms which came into the medical language during the war years have been added. Terms pertinent to radioactivity and radioactive isotopes are included. This dictionary maintains its great value to the physician.

ANNUAL CLINICAL CONFERENCE HIGHLIGHTS CENTENNIAL YEAR OF THE CHICAGO MEDICAL SOCIETY

Attendance at the 1950 Clinical Conference of the Chicago Medical Society should be a MUST on your schedule. Set aside four days—February 28, March 1, 2, and 3, 1950, for valuable postgraduate observations in the great medical center of Chicago.

There will be clinical sessions and scientific lectures by the nation's foremost medical authorities and educators.

There will be selected scientific and technical exhibits, displays that will dramatize medical developments "up-to-date."

There will be color television of actual surgical procedures, and also black and white telecasts. Observers will see close-up surgical techniques and medical procedures in full color detail.

There will be entertainment. The conference dinner will highlight speakers and entertainers.

Mark your calendar now for February 28, March 1, 2, and 3, and make your reservation direct to the Palmer House which will be the headquarters for this great 1950 meeting.



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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngo-
scope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Broc. Soc. Exp.
Biol. and Med., 1934, 32,241; N. Y. State Journ. Med., Vol.
35, 6-1-25, No. 11, 590-592.*

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DIAGNOSIS AND PRESENT TREATMENT OF PYOGENIC MENINGITIDES*

WILLIAM A. REILLY, M. D.
Little Rock

These remarks are about the common types of purulent meningitides—meningococcal, influenzal and pneumococcal. Tuberculous meningitis, third or fifth most common type, while it may be considered purulent, will not be considered.

The discovery of the sulfonamides and the antibiotics naturally are of the greatest importance in the present good results of therapy for these diseases. The mortality has been reduced from practically 100 per cent for pneumococcal and influenzal meningitis, for meningococcal meningitis 90 per cent without serum and 40 per cent with serum, to about 50-60 per cent for first 2 and 10 per cent for the last (Levinson). The morbidity too has been reduced; for instance, prophylactic use of sulfadiazine against the meningococcus has greatly reduced the incidence of that meningitis when epidemics threaten as in army camps, etc.

All forms of meningitis occur most frequently in the first three years of life.

Clinical Picture: We will comment on some of the findings in older children and then in infants. The onset is usually sudden but can be gradual. Headache is one of the earliest and most common complaints; it often is severe. Vomiting, unrelated to food ingestion, occurs early also. Fever is very common and high. Convulsions are frequent and usually generalized. Not all meningitides lie in opisthotonus; this occurs in the most severe forms and then the patient must of necessity lie on his side. Usually neck rigidity and signs of meningitis are mild in the early stages and severe later. The high-pitched weak, plaintive cephalic cry or shriek is not infrequent. Reflexes early are usually hyperactive. Paralysis, eye symptoms, unbi-

lateral signs, etc. usually are late. Rapid respiration, anorexia, nausea, vomiting, usually constipation and occasionally diarrhea, retention of urine and albuminuria are to be found even early. The skin dries early. Not all cases due to the meningococcus have the purpuric or petechial rash.

In infancy it is often quite difficult to detect meningitis by history or examination. Onset may be sudden or gradual. About 25 per cent of cases do not have fever. The open fontanelle and sutures give with increased intracranial pressure so that there is a degree of compensation and some of the classical signs and symptoms may not be found. The fontanelle is bulging and tense and an increase of the normal cracked-pot note (Mac Ewen's sign), cephalic cry and convulsions are usually present. If dehydration has occurred, the fontanelle may not be bulging. Nuchal rigidity, Brudzinski's and Kernig's signs are usually absent in these infants. Fever and a bulging fontanelle, especially with a convulsion, is very suggestive of meningitis.

The most certain way of making a diagnosis is the examination of the spinal fluid and this should be done in any doubtful case. We do it in any child here having had a convulsion and fever; or if any physician referring the case suspects meningitis. It is very difficult at home in the early days of the disease to be reasonably sure of meningitis and to convince some families of the necessity and safety of a spinal puncture. In hospital and clinic practice, we have several advantages—one being the referring physician has suspected meningitis and the signs often are advanced when the patient arrives here. One of the more common misleading diagnosis has been poliomyelitis or vice versa. Occasionally in meningococcal meningitis, the fluid might be completely normal in the first 48 hours; thereafter it always yields positive evidence of that organism, especially if the disease is untreated. The fluid usually is under increased pressure. It usually will not have a ground glass appearance until over 300

* Read before the Seventy-third Annual Session, Arkansas Medical Society, Little Rock, April, 1949. From the Pediatric Department, University of Arkansas School of Medicine.

cells/cu. mm. are present. It is not necessary to stress that the great preponderance of cells are polymorphs. A smear should be made from the centrifugalized sediment. It should be carefully stained with good Gram's stain. The meningococcus might be hard to find early in the disease; if the stain is good, it is gram-negative color, kidney or coffee-bean shaped, pairing are all necessary findings for this valuable microscopic diagnosis. The pneumococcus is found more easily and in greater numbers than the meningococcus. Pneumococci are ovoid, paired end-to-end, gram-positive and encapsulated by a bale around the pair. To show the capsule well, special stains are needed (Smith's, Rosenow's, and Hiss' methods). Again cultures establish the etiology. The influenzal organism is often difficult to find. They are so pleomorphic and many are so small it is difficult to recognize whether one is dealing with a coccus or a bacillus. The smallness of the cocci and thread-like forms, we find most helpful in the microscopic diagnosis; they are gram-negative. They show capsular swelling with antisera. If one has access to differential culture media for these organisms, (I am very conscious of the limitations of practice) so much the easier for diagnosis. Meningococci and influenza are difficult at times to grow.

In purulent meningitis the sugar level in the fluid is usually low, the chlorides about normal and the protein usually raised, should the practitioner be able to make these tests.

A purulent spinal fluid in an infant under two years is due to influenza bacillus (type B) in 80 per cent of the cases. In any age group, if a focus of infection exists, particularly otitis media, mastoiditis, sinusitis or pneumonia one should also suspect pneumococcus and even streptococcus, which can also cater from sinuses, middle ear or skull fracture.

Treatment of Meningococcus Meningitis

This common type will be used as a general example.

Prophylaxis—sulfadiazine 1. to 2. grams daily for 4 to 5 days by mouth will protect all contacts very efficiently. There are very few multiple cases of the disease in families but during crowded conditions this might occur.

General treatment—bed rest, good nursing and supportive care, adequate fluids and electrolytes, sedation, if necessary by morphine or demerol, care of the bladder (catheterization if needed) and bowel care are very helpful.

Specific treatment—sulfadiazine is the most

efficient and safest sulfaonamide to use; sulfathiazole or sulfamerazine also are very good. The oral dose is 2 to 3 grams per pound for the first 24 hours. The intravenous dose is half of this. If the patient is unconscious or very ill, the first dose should be given into a vein as a 5 per cent solution of the sodium salt and repeated every 8 hours. When it is not possible for us to enter veins, we give the sodium sulfadiazine intramuscularly as a 10 per cent or occasionally 25 per cent solution; the amount of local reactions is not so serious as to interdict such strength or route. This has helped us a lot by saving the time of the house staff and rapidly helping the patient. Usually our patients are very ill or in a coma and therefore we give the first dose intravenously to raise the blood level high enough for spilling into the spinal fluid. When swallowing is possible, the drug is given orally every 4 to 6 hours in doses of 1-6th to 1-4th the 24-hour amount. Plenty of fluid and 2 to 4 grams of soda bicarbonate or other alkali should be given to help excretion and prevent crystals in the kidney. For the second 24 hours, a dose of $1\frac{1}{2}$ grains per pound should be given. On the third day, the dose should be reduced to 1 grain per pound and this amount continued until the temperature has remained normal for 48 hours. After that, the dose should be reduced to $\frac{1}{2}$ grain per pound for 5 to 7 days as relapses are common if the drug is withdrawn before that. In mild cases, the intravenous dose is not necessary and the oral route is very satisfactory.

Penicillin is the chief adjunct for meningococcus therapy. Sulfadiazine alone usually will be sufficient. Penicillin has now replaced the disadvantageous and questionably useful serum used formerly. Penicillin should be given immediately with sulfadiazine to all comatose or irrational patients or those with fulminating infection and to those whose response after 24 to 48 hours of sulfonamide has not been satisfactory. We give 20,000 to 50,000 units depending on the patient's size, intramuscularly every 4 to 6 hours daily, decreasing the dosage gradually with improvement and stopping after 5 days of normal temperature. I think we give too much of this. Crystacillin or duracillin given once daily or every other day is more practical.

We have discontinued antiserum and antitoxin therapy for results are inferior and bad reactions may occur. However, a case not doing well after 4 or 5 days of the above therapy should have whatever advantages can be given by serum or antitoxin. They are difficult to obtain at certain times or places.

We have discontinued intrathecal therapy for

any meningitis, as it is unnecessary; the diseased meninges are permeable enough to the drugs in the blood. Naturally, the greatest advantage is the avoidance of irritation of the meninges by the "chemical meningitis," arachnoiditis and adhesions which medication induces.

Influenza Meningitis

Three materials in combinations have been the most effective up to recently. They are sulfadiazine or sulfamerazine, streptomycin and H influenza—type B rabbit antiserum. The dosage of the two sulfanomides is the same as outlined. Streptomycin has given good results by itself but only in some cases. We give 25 to 30 mgms. of streptomycin per pound per day up to 2 or 3 gms. intramuscularly in 4 or 6 doses; usually 4 doses daily are sufficient. Too much is wasted. Alexander recommended 25 to 50 mgms. intrathecally daily for only 3 to 5 days; Hoyne and Reimann claim as good results without any intrathecal medication of any type for any meningitis. Since January, 1949, we have had the same good results. The intramuscular streptomycin should be continued until cultures are negative and temperature is normal for from 3 to 5 days; this usually takes 10 to 14 days of treatment.

If after 48 hours the patient has not improved definitely, we recommend the antiserum in doses of 100 to 200 mgm. of antibody nitrogen (4 to 8 vials) intravenously. If facilities are available the patient's serum should be checked for antibody; a titre of 1:8 or more should be maintained. Lacking this facility give 200 mgms. of antibody nitrogen. The antiserum costs about \$200 for 200 mgms.; Squibb & Sons, are the only manufacturers.

We recommend all three materials for those comatose or under 6 to 7 months of age.

Aureomycin recently has been found quite

effective for influenza meningitis. It is too early to be certain that this antibody is more effective than any other treatment. It is best given with streptomycin. Aureomycin is given in doses of 25 to 30 mgms. per pound every 24 hours administered by mouth. There is nauseating results in some patients. Special preparations are available for intramuscular injection of aureomycin in the dose of 1 mgm. per pound every 24 hours in three divided doses. If this antibody proves as helpful as indicated, the treatment of this meningitis will be greatly simplified and much expense saved.

Pneumococcus Meningitis

The medication of choice is penicillin with sulfadiazine an adjunct only. Penicillin dosage which we use is 20,000 to 50,000 units intramuscularly, depending on the size of the patient, every 4 hours. Some cases will require much higher doses of penicillin. Dowling and others have recommended as much as one million units for adults every 2 hours for some days. We have not found this great dose necessary in children; perhaps we have been dealing with a less purulent type of meningitis. One should keep in mind the meningococcus antibody, if it is procurable for those cases not responding well to treatment. This organism is a very mortal one and the more difficult of the three types discussed to treat successfully.

For meningitis due to other pyogenic organisms, we recommend therapy as for the meningococcal meningitis. If colon is the cause use streptomycin and sulfadiazine; if typhoid bacillus is present chloromycetin is the choice, streptomycin is not very helpful. If staphylococcus is the cause, the antibody aureomycin alone is the most effective therapy.

THERAPEUTIC AGENTS FOR BACTERIAL MENINGITIS

TYPE OF MENINGITIS	THERAPEUTIC AGENT				
	SULFADIAZINE	PENICILLIN	STREPTOMYCIN	AUREOMYCIN	SERUM
MENINGOCOCCIC	††	†	?	0	†
INFLUENZAL	†	0	††	††	††
PNEUMOCOCCIC	†	††	?	0	†
STREPTOCOCCIC	†	††	?	0	0
TUBERCULOUS	0	0	††	0	0
ESCHERICHIA COLI	††	0	††	0	0
SALMONILLA	?	0	††	0	0
PSEUDOMONAS AERUGINOSA	0	0	††	0	0

†† MOST EFFECTIVE AGENT

† EFFECTIVE AGENT

?

VERY SLIGHT OR QUESTIONABLE EFFECT

0 NO EFFECT

MENINGOCOCCUS MENINGITIS

1948	U. S. P. H. SERVICE		3,280 CASES			
UNITED STATES	43 - 47 MEDIAN		7,999 CASES		20 - 23% MORTALITY	
ARKANSAS	A. P. H. DEPARTMENT		34 CASES			
			7 DEATHS		20%	
JULY 1, 1947, to JUNE 20, 1949						
UNIVERSITY OF ARKANSAS HOSPITAL	CHILDREN		26 CASES			
			2 DEATHS		7.5%	
TYPE OF MENINGITIS	0 - 6 MOS.	7 - 12 MOS.	1 - 2 YRS.	3 - 6 YRS.	7 - 10 YRS.	10 - 14 YRS.
MENINGOCOCCUS	7, 14, 90					
26 CASES	SP D		2, 3, 4, 10	1, 1, 3, 4	2, 3	1, 1, 1, 1
2 DEATHS						Deaf
7.5%						4, 4, 5, 8
INFLUENZA	1, 2	30, 150	1, 6, 9	2, 7, 11		
22 CASES		D HYD.	D			
2 DEATHS			21, 21, 21			
10%			SP SP			
PNEUMOCOCCUS	4, 7	7, 7	4, 14			
8 CASES			D			
1 DEATHS						
12.%						

The figure indicates duration of disease before treatment; SP—spastic, HYD.—hydrocephalus, D—death.

SUMMARY

This paper consists of some remarks on diagnostic problems of purulent meningitis and the present best accepted

treatment for this disease. The results of treatment in children are given for the past two years at the University of Arkansas Hospital.

OBITUARY

JOHN E. CUNNING, Little Rock, age 53, died December 16th of injuries received in an automobile accident. He was born at Lonoke, March 27, 1896, and graduated from Vanderbilt University School of Medicine in 1924. In addition to his membership in the Pulaski County Medical Society and the Arkansas Medical Society, he was a member of the Masonic bodies, the Shrine and of the Methodist Church. Surviving are two sons.

J. J. MORROW, age 88 years, Mountain Home, died December 13th. A graduate of the University of Arkansas School of Medicine in 1884, he was a honorary member of the Arkansas Medical Society, a past-president of the Ninth Councilor District Medical Society, a fellow of the American Medical Association, a member and former secretary of King Hiram Lodge, F. & A. M. Surviving are two brothers, two sons and a daughter.

JOHN S. JENKINS, age 75, Pine Bluff, died December 1st. Born at Lake Providence, Louisiana, he attended Mount Lebanon Military Academy, Washington and Lee University and graduated in medicine from the University of Nashville Medical Department in 1899. Following an interneship at Parkland Hospital, Dallas, he first located at Douglas and moved to Pine Bluff in 1909 as resident surgeon of the Florence Sanatorium. During World War I he served in the Army Medical Corps and was discharged with the rank of major. He was a member of Sigma Chi and Alpha Kappa Kappa fraternities, a fellow of the American Medical Association and of the American College of Surgeons, the Jefferson County Medical Society, the American Legion, the Sons of Confederate Veterans and was visiting orthopedist and formerly chief of staff, of the Davis Hospital. He is survived by his wife.

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PIONEER DOCTORS OF GARLAND COUNTY*

BY MRS. TURNER WOOTTON, HOT SPRINGS

In the pioneer days herein considered, Garland County was a part of Hot Spring County. As far as our records show, the only doctors locating in this region during that early date, located at the Spa in order to treat visiting sick who came by way of Malvern, the nearest railroad point, then by stagecoach to Hot Springs.

The first reputed graduate of medicine to locate in Hot Springs is said to have been Dr. William H. Hammond, who was born in Montgomery, Alabama, June, 1825; graduated Louisville Medical College in 1847; married Juliette Elizabeth Peay, of Little Rock, in 1850; and then moved to Hot Springs to begin his professional career. He built up a large practice; served in the State Senate four years; was charter member of the First Masonic Lodge in Hot Springs. He died at the early age of 34.

Probably the most colorful character to practice medicine in Hot Springs during the post Civil War period, was Dr. George W. Lawrence. He was no less skilled with sword and revolver than with the lancet. It was his boast that: "He practiced medicine professionally; welcomed his friends socially, and fortified himself against the ills of life philosophically." He graduated from the University of Pennsylvania in 1846, was surgeon in the Confederate Army, Chief Surgeon Trans-Mississippi Department. Twice appointed delegate to the British Medical Association by the American Medical Association. In 1876 was appointed Commissioner for Arkansas to the Centennial Exposition at Philadelphia. He was an outstanding figure of the post Civil War period. He was associated with Dr. Prosper H. Ellsworth in the operation of a hospital on the present site of the Fordyce Bath House.

During this early period there was, at times, only one practicing physician at the Spa. Dr. Knode found Dr. Lawrence here and pretty well in control of the local situation. Shortly after Dr. Knode arrived, he was called on to treat a gunshot wound of the arm. No sooner done than he was notified by a prominent local gambler to extend no further medical aid under penalty of _____. Dr. Knode sent back he was a doctor first, etc. Dr. Knode shot the gambler on sight. Was exonerated by "the law," but did

not remain in Hot Springs very long thereafter.

Came about this time (1863) from Virginia, Dr. Almon Brooks, who, by strict adherence to his own business and a friendly personality, began to build quite a large clientele. It is said that he was the first physician here to use Mercurial Inunction in the treatment of syphilis. His practice soon grew to such proportions that he persuaded Dr. A. S. Garnett to accept partnership with him.

In a very few years following, Dr. Brooks sent back to Virginia for another acquaintance, and Dr. G. C. Greenway joined the triumvirate partnership.

Shortly after the advent of Dr. Greenway in Hot Springs. Dr. Brooks sold out to his former partners, and moved to Chicago, where he amassed a huge fortune as the "Hot Springs Specialist."

Dr. Algernon Sidney Garnett (1834-19) was born in Wakefield, Virginia. Was educated at the Catholic College in Georgetown and the University of Pennsylvania, 1858. He married Alice Evelyn Scott, of Alabama. After his graduation he entered the United States Navy. When war was declared between the States, he resigned his commission in the Federal Navy, and came South, only to enter the Confederate Service. He was surgeon on board the Merrimac during her encounter with the Monitor, and became the last surviving member of that historic crew.

Dr. Garnett had a most lovable personality and a marvelous memory for names and faces.

Dr. George A. Greenway came to Hot Springs at the insistence of a former acquaintance, Dr. Almon Brooks. After Dr. Brooks left Hot Springs, Drs. Greenway and Garnett are said to have seen more patients daily than any other office in Arkansas. It was not unusual for these two men to consult with more than three hundred people day after day, during the winter seasons, in Hot Springs. They were mild mannered gentlemen in lurid contrasts to many who made their way to Hot Springs to practice medicine in those early days.

Contemporaries of Dr. Brooks, Greenway and Garnett, were Drs. S. W. Franklin, O. A. Hobson, Harry W. Rector, G. W. Lawrence and P. H. Ellsworth.

Dr. Prosper H. Ellsworth, a Canadian by birth, a Rush Medical College graduate in 1861, surgeon in Federal Army during Civil War, came to Hot Springs after hostilities ceased, and became widely known. Was associated with Dr. George

* Presented by the Biography Committee, Woman's Auxiliary to the Arkansas Medical Society, Mrs. Chas. W. Dixon, Gould, and Mrs. C. W. Garrison, Little Rock.

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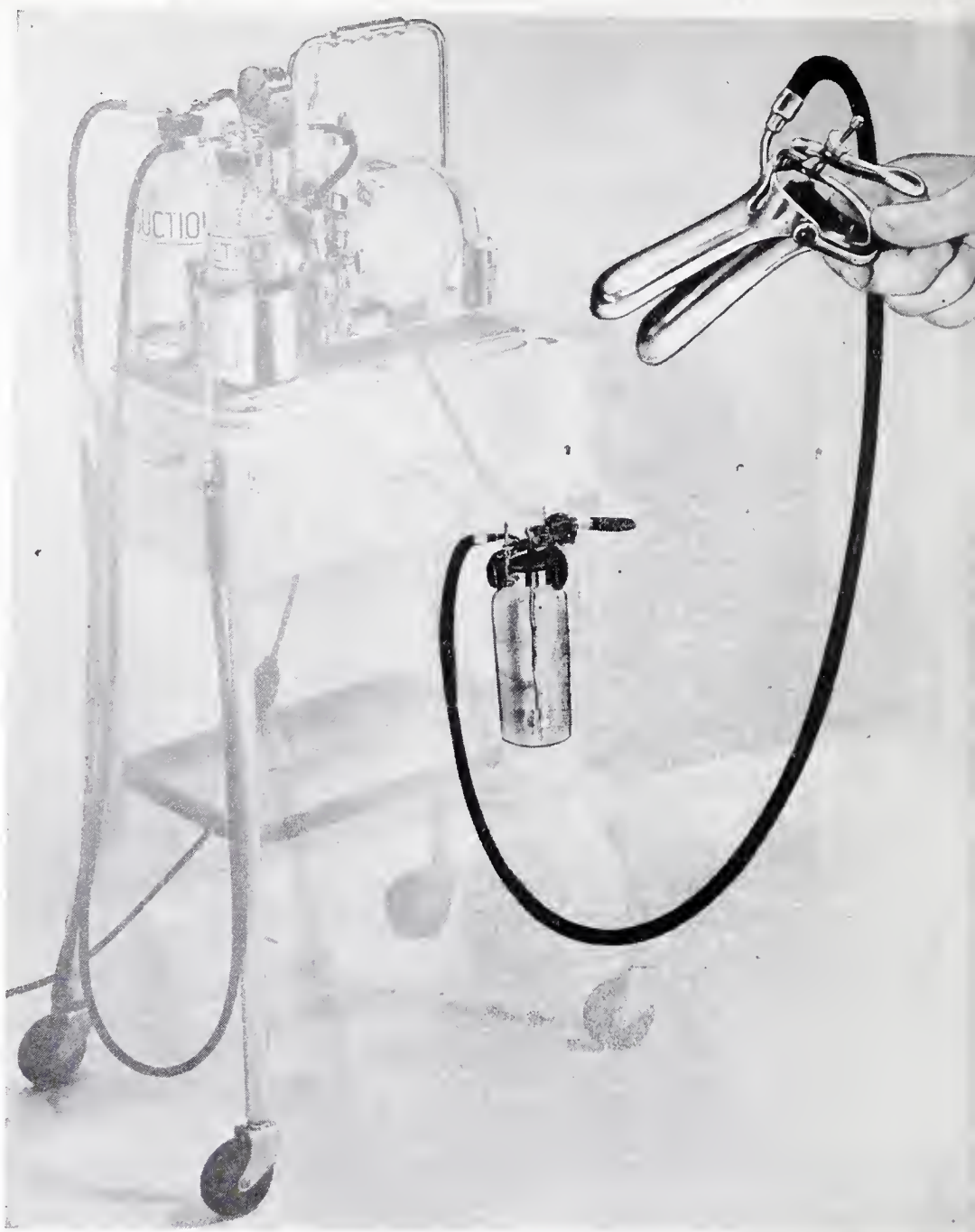
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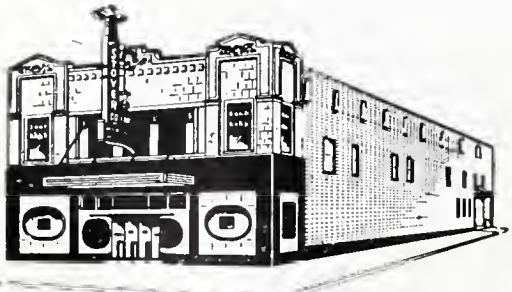
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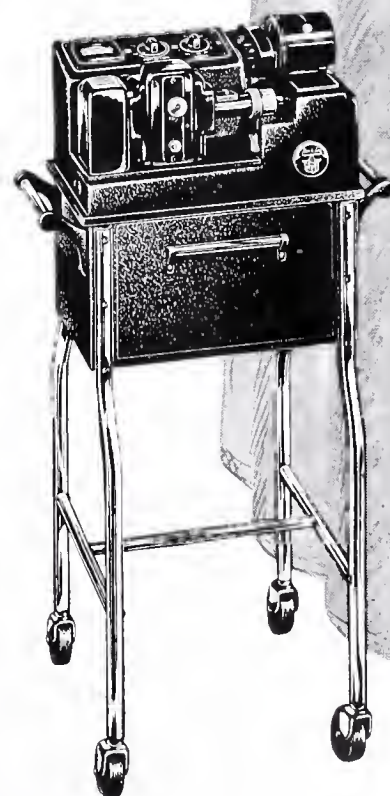
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W. Lawrence in the operation of a hospital or sanatorium.

About this period quite a few men who had served throughout the Civil War as hospital attendants or stewards, began to settle in the community and assume the title of doctor, without more ado than hang up a sign to that effect. One of these men achieved quite a following as a graduate of Heidelberg before he was exposed as an imposter.

During the '70's, there were some notable additions to the Hot Springs medical fraternity.

Dr. William H. Barry (1836-1914) came from Sparta, Alabama. He married a girl, Miss Louise Watt, from South Carolina. Dr. Barry was intensely interested in civic affairs as well as being a busy practitioner. He owned and operated the first charity hospital in Hot Springs, and devoted much time throughout his entire career to the care and upkeep of this establishment. He also served on the school board and as City Councilman for a great many years. He had two sons, who also became physicians, Drs. Linda and Pat Barry.

Dr. J. M. Keller (1832-19) graduate of University of Louisville, 1852, came to Hot Springs in 1877. In appearance, Dr. Keller was the typical Kentucky Colonel—which honorary title he bore.

Dr. Samuel Paxton Collings (1845-1917) a graduate of Jefferson Medical College in 1870, was married to Sarah E. Loudon of Indianapolis in 1875. Dr. Collings practiced in Philadelphia and Indianapolis both prior to coming to Hot Springs in 1878. He was a member of many medical organizations and the recipient of numerous honors.

He was later joined by his brother, Dr. Howard Paxton Collings, and they were associated in practice until his death.

Dr. Samuel Watkins Vaughan (1838-1910) was born in Virginia, and at an early age moved to Alabama; graduated New York Medical College in 1859. Came to Hot Springs in 1870. His wife was Virginia Harrison of Springfield, Alabama.

Dr. John A. Blaydes (1836-1917) was born in Fayette County, Kentucky, and was married to Miss Mary Jane Owings, also of Kentucky, in 1860. He was a graduate of Transylvania University of Lexington, Kentucky. He came to Hot Springs in 1876, and was later associated with his son, J. Reece Blaydes, in practice.

Dr. James T. Jelks (1849-) graduate of the University of Nashville, 1870. Came to Hot Springs in 1877.

Dr. Jelks was a surgeon and gynaecologist of note, and opened and operated the Ozark Sanatorium for the convenience of his patients. He was later joined by Dr. Thomas E. Holland, who succeeded him at his death. Dr. Jelks had two sons, who graduated in medicine and practiced their chosen profession here throughout their medical lives.

Some of those practicing here in the '70's were Dr. Richard Taylor, a high Mason, Dr. E. A. Shipper, Dr. P. B. Buchanan, Dr. L. S. Ordway, Dr. S. W. Franklin and others.

In the '80's came Dr. M. G. Thompson, Dr. W. S. Walker, Dr. A. U. Williams (1856-19) born in Missouri, graduate of Missouri Medical College, 1878. Came to Hot Springs 1883. Was married to Elizabeth Birkett of Todds Point, Illinois. Was a prominent and popular figure on the streets of Hot Springs for many years.

Dr. John Hutchins Gaines (1830-1909) born in Natchez, Mississippi. Graduate of Tulane University. He first moved to Chicot County, where he was married to Miss Helen Maria Fouche of Culpepper, Virginia. They moved to Hot Springs in 1885.

Dr. Charles Dake (1860-19) came to Hot Springs shortly after he graduated from the University of Tennessee in 1881. He was followed by his brother, Frank (1864-19) who graduated at the same school in 1887. The latter devoted his entire medical life to Bacteriology, while Dr. Charles built up an enormous practice.

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY POST-CLINICAL TOUR

The New Orleans Graduate Medical Assembly is sponsoring an interesting post-clinical tour to follow the 1950 meeting in New Orleans. On Saturday, March 11, a party composed of doctors and their wives will leave by plane for San Juan, Puerto Rico. The itinerary will also include the Virgin Islands; Ciudad Trujillo, Dominican Republic; Kingston and Montego Bay, Jamaica and Havana.

Medical programs and visits to hospitals have been arranged and the trip also includes a full schedule of sightseeing.

Details and a complete itinerary are available at the office of the Assembly, Room 105, 1430 Tulane Avenue, New Orleans 12, Louisiana.

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EDITORIAL

A ONE-SENTENCE EDITORIAL

We wonder if anyone ever asked a Navajo Indian, a ward of the Federal government, what he thinks of the welfare state and security?

AMERICAN MEDICAL ASSOCIATION MEMBERSHIP DUES

The House of Delegates of the American Medical Association at its recent Washington session voted to assess members \$25 annual dues. Thus members of county and state medical societies who have been "members" of the American Medical Association throughout the 102 years of its existence without contributing toward the expenses of that organization will now by their assessments contribute to support the manifold activities of the national body. Fellowship, which has been so often confused with membership in the past, remains as before and dues of fellows are \$12 per year. For the year 1950 fellows will pay \$37 while members will pay \$25 to the American Medical Association as their dues. A physician will now pay dues to his county society,

to his state society and to the American Medical Association. All such dues are to be paid through the county society secretary who will transmit state and national dues to the state secretary. Fellows of the American Medical Association are asked to make direct payment of their fellowship dues of \$12. The need for increased financial support has been felt by county and state medical societies. The need of the national organization is even greater. Members of the Arkansas Medical Society will assist in the furtherance of the aims and ideals of organized medical effort by making prompt payment of all dues to their county society secretaries.

BLUE CROSS-BLUE SHIELD IN ARKANSAS

Members will be interested in the report of Arkansas Medical and Hospital Service, Inc., to the Council of the Arkansas Medical Society. With a working capital of \$30,000 memberships were first offered to the public on January 15, 1949. Since this date the Plan has contracted with 72 hospitals and 900 physicians. Over 400 employee groups covering nearly 24,000 people are enrolled. A campaign has started in 20 counties offering membership to existing Farm Bureau members. All Trinity Hospital Plan members have been changed to the program giving some 5,000 persons the benefits of the state plan. Since April 30th, operation of the Plan has been financially profitable: Dues income from membership has increased from about \$9,000 to about \$81,000; the cash position of the Plan was \$61,277.48 on August 31st. The operating deficit of the Plan has decreased from over \$15,000 on to about \$11,000. During the entire period of operation the Plan has paid to doctors and hospitals (figures of October 5, 1949) to \$49,560, or 60.53% of the entire income.

The growth of the Plan as briefly outlined above has not been without difficulty. Competition from commercial insurance companies has been aggressive and constant. There have been some misunderstanding with doctors, hospitals and the public, all of which will decrease with more general acceptance of the Plan and more widespread knowledge of the program.

Physicians have a vital interest in the continued growth of the Plan. It is the physician who can influence most the acceptance of memberships by the public and it is the physician who, in his dealings with the patient, materially determines the financial success or failure of the Plan. It is he who must decide whether the Plan will be

abused in its provisions and over-utilized with likely failure. Doctors must realize that this Plan was created by and for them; as a method whereby the public might budget against the costs of illness in a voluntary manner rather than by governmental compulsion.

MORRIS FISHBEIN, M. D.

On December 1, 1949, Morris Fishbein retired from his office as editor of The Journal of the American Medical Association after thirty-seven years of service. By his unusual ability and talents he made The Journal the greatest medical publication in the world. Similarly he brought Hygeia to its present eminent position as a health magazine. He has given energy and tireless enthusiasm to the interests of the American Medical Association and the American physician. An outstanding public speaker, he has received the plaudits of both lay and professional audiences on hundreds of occasions. In the field of medical writing, he is received as an authority.

American medicine has greatly benefited by his efforts. Our full gratitude goes to him for exceptional diligence in furthering the aims, the ideals and the continuing education of the medical profession: May his days be long and happy in his new activities.

HOTEL RESERVATIONS FOR 1950 ANNUAL SESSION

Advance hotel reservations are urged for members who plan to attend the 1950 annual session of the Society in Fort Smith April 17th, 18th and 19th. Requests for reservations should be directed to Dr. John D. Olson, Chairman, Hotel Committee, Hotel Goldman, Fort Smith, and members should specify whether reservation is desired at the Goldman or Ward Hotels. The Auxiliary will meet at the Ward Hotel; The Society, at the Goldman.

RANDOM THOUGHTS OF THE SECRETARY

November 19th. In the densest football traffic ever, Oklahoma City to Norman, late to the Oklahoma University-Santa Clara contest with the favored Sooners hard-pressed to maintain the advantage, affording a more or less neutral observer many a thrill, and returning by rail, a preferable travel mode.

November 20th. Meeting at Oklahoma City's Skirvin Hotel, where courtesy and friendliness to the guest reaches a peak with the presidents from Oklahoma, Arkansas, Kansas, Louisiana, Texas and Missouri and Trustee Blasingame with profit to all from the discussions and in the afternoon earning our ride homeward by driving the car Earle Hunt borrowed for the trip.

December 5th. To Adams Field to give Arkansas' Outstanding Physician of the Year a send-off as he goes

forth to compete for national honors.

December 6th. Prior to the county society meeting visiting with the Richardsons three, enjoying the rugs and artistry of India which Fount brought to his home, finding our favorite "Arizona Highways" in position of honor on the reading table, and to the Washington Hotel where the county society meets with its congressman, the second time within the fortnight that we have heard a returned congressman speak on national legislation, fully convincing us of the value of these meetings which some of our county societies are initiating at this season.

December 7th. From the press dispatches there might be some question as to whether the Washington reception was given by the Arkansas Medical Society or by the Governor. This item will certify, in its limited circulation area, that the party was by the medical society and that the governor was one of the guests.

December 8th. On this our natal day, celebration is afforded the passage of another of the intensely-lived years of our life by receipt of the American Airlines award of "Admiral of the Fleet"; congratulatory messages (in the main) from associates and friends in a happy number, and tonight to the fraternity banquet where youth reigns but permits oldsters to enter into the spirit of the occasion, even to being toastmaster.

December 17th. With Bill, junior, guests of Bill Shepherd way down in Arkansas county on Pecan Lake where our average in nimrod skill for the current season is raised by happy duck shooting and some of the Idaho hardships are missing. The vicissitudes of an active life attend us as we collect one shot in the cheek from a neighboring blind.

RESOLUTION

December 6, 1949.

WHEREAS, The Great Physician has seen fit to take from us our beloved friend and colleague, Dr. John S. Jenkins, we, the members of Jefferson County Medical Society mourn and deeply regret his passing, and,

WHEREAS, as a physician and surgeon he brought unfailing devotion and professional honesty to those in need of his services for more than fifty years, and,

WHEREAS, this community has lost one of its most respected and honored citizens, and our profession has lost one of its most ethical and able members,

BE IT RESOLVED, that the members of Jefferson County Medical Society express to his family their deepest sympathy in the loss they have sustained; that a copy of these resolutions be made a matter of record in the minutes of the Society; a copy be sent to his family, and a copy be sent to the Journal of the Arkansas Medical Society.

A. Fowler, Jr.,
President, Jefferson County
Medical County,
E. Frank Reed,
Secretary, Jefferson County
Medical Society.

THE ROAD AHEAD

WILLIAM M. GAMBRELL, M.D.

President-Elect, State Medical Association of Texas
Austin, Texas

A small book recently published, "The Road Ahead" * by John T. Flynn,† paints a dramatic picture of England's march toward its present socialistic state and draws a parallel with what is now happening in the United States. This book offers assistance to anyone who wishes to understand the changing social and political scene.

Mr. Flynn presents clearly how England was invaded with the socialistic idea in what was a most insidious manner. It is peculiar to think that an organization like the Fabian Society, which was organized in England in 1883, according to Mr. Flynn, could work so effectively toward the socialization of all England and completely avoid the use of the word "socialism" and in addition keep the English people from knowing they were actually being socialized! It is apparent from this book that with all his ability, Lloyd George was completely without understanding as to the Party's intention. Through the capture of the Labor Party and the Liberal Party it did not take the Socialists too long to dominate completely the thinking of the English Parliament. Mr. Flynn says, "Thus only 18 years after the start, literally from scratch, of the Socialist drive, their leader was England's Prime Minister. Instead of cutting the claws of the Labor government, Asquith had cut the throat of the Liberal Party. Asquith's Liberals and Stanley Baldwin's Conservative voters represented a vast majority of the people. But Asquith turned the machinery of the British Empire over to the Socialist Labor Party representing only a third of the electorate and with only 191 votes out of 615 seats in the Commons."

It is interesting to see how closely the pattern in America is following the pattern in England. The distinction which Mr. Flynn makes between Communism in Russia and Socialism in England leaves no doubt in the mind of the reader that they are essentially one and the same thing, the only difference being in the policy of attack of the two organizations. Russian Communism is a type of socialism which seeks victory by a blow on the head, while the English type, he says, is a

Fabianistic policy which is giving America more trouble now than the Communistic policy. He says further that we are fighting vigorously a few hundred thousand Communists of the Russian socialistic philosophy and embracing the socialistic policy that is taught and promulgated by England.

The extent to which socialism has crept into our society is suggested in a chapter entitled "The 'Kingdom of God,'" which no one, Christian or otherwise, can afford to overlook.

In a recent syndicated column, Westbrook Pegeler said: "On second reading, I sincerely believe that John T. Flynn's new book . . . called 'The Road Ahead—America's Creeping Revolution,' is one of the greatest political pamphlets in our history. Flynn awakens me to the realization that Socialism is Communism and that therefore the 'planners,' as our Socialists call themselves for disguise, are promoting the preparatory phases of Communism. . . . I earnestly urge you to read it carefully . . . and be warned."

For those concerned with reversing the direction in which he believes America is going—and this should include every doctor and all other citizens as well—Mr. Flynn suggests ten bases for action:

1. We must put human freedom as the first of our demands.
2. We must stop apologizing for our capitalistic society.
3. We must not take one more step into socialism.
4. We must get rid of the compromising leaders.
5. We must recognize that we are in the midst of a revolution and begin to fight it as such.
6. We must put an end to the orgy of spending.
7. We must put an end to crisis government.
8. We must stop "planning" for socialism and begin planning to make our free system of private enterprise operate at its highest capacity.
9. We must set about rebuilding in its integrity our republican system of government.
10. We cannot depend on any political party to save us. We must build a power outside the parties so strong that the parties will be compelled to yield to its demand.

* Published by the Devin-Adair Company, New York, 1949. Available from the publisher in a cloth bound edition at \$2.50 per copy and from the Committee for Constitutional Government, Inc., 205 East Forty-Second Street, New York 17, in a special paper bound edition at \$1.00 per copy.

† Editor, lecturer, economist, educator, and author of "The Roosevelt Myth" and other books.

CORRESPONDENCE

Dear Doctor Brooksher:

Numerous requests have recently come to us

from physicians located in various parts of the state relative to the possibility of receiving instruction in the use of modern anesthetic agents and techniques.

In establishing a Department of Anesthesiology at the University of Arkansas School of Medicine one of our specific aims for improvement of the quality of anesthesia administration in the state has been to offer our services and facilities under any arrangement which will be helpful and at the same time compatible with other time demands of the interested but busy practitioner. Thus we have decided, instead of arranging periodic clinic sessions, to invite any interested physicians of Arkansas to arrange to come and observe and work in our department during any time they may have available. No tuition charge will be made.

In addition, we are arranging a two-year residency program in Anesthesiology directed toward qualification of the individual by the American Board of Anesthesiology, and we will be happy to communicate with anyone interested in this program.

I would appreciate it very much if you would be so kind as to inform the members of the state society, possibly by an article in the Journal, or by any other means that seems good to you, about our desire to be of service.

Edwin L. Rushia, M.D.,
Associate Professor and Head
Department of Anesthesiology.

PERSONALS AND NEWS ITEMS

The State Medical Board of the Arkansas Medical Society has elected the following officers: President, Chas. H. Lutterloh; Vice President, Ray E. Williams, and Secretary-Treasurer, Joe Verser.

W. A. Reilly, Little Rock, attended the San Francisco session of the American Academy of Pediatrics during November.

Dr. and Mrs. L. J. Kosminsky, Texarkana, spent a recent vacation in Miami.

J. K. Thompson, Fort Smith, recently took special work in New Orleans.

"Disseminated Calcification of the Pancreas, with Case Report" by Louis P. Good, Texarkana, appears in *The Southern Surgeon*, November, 1949.

Dr. and Mrs. W. C. Langston, Little Rock, spent a recent vacation in Colorado.

V. N. Kennedy, Fort Smith, took postgraduate work in New Orleans during November.

The following were registered at the Cincinnati session of the Southern Medical Association: C. A. Archer, DeQueen; C. A. Archer, Jr., Conway; Willis E. Brown, Little Rock; Eva F. Dodge, Little Rock; I. F. Jones, Fort Smith; Jerome S. Levy, Little Rock; O. C. Melson, Little Rock; L. H. McDaniel, Tyronza; R. B. Robins, Camden; J. M. Roy, Forrest City, and Kenneth Siler, Siloam Springs.

Charles S. Paddock, formerly of Fayetteville, is now located at 215 First National Bank Building, El Paso, Texas.

J. K. Grace, Belleville, has returned to active military service and is assigned to the Office of the Air Surgeon, Washington.

George W. Jackson, Little Rock, has been appointed regional representative on the mental hospital service of the American Psychiatric Association.

Henry G. Hearnberger has been elected surgeon of the Stephens post, American Legion.

Dr. and Mrs. C. C. Reed and Dr. and Mrs. Vernon Newman spent recent vacations in New Orleans.

PROCEEDINGS OF SOCIETIES

Craighead-Poinsett County Medical Society met in dinner session December 7th. Hon. E. C. Gathings, congressman, addressed the meeting and a motion picture on trichomonal infection was presented. Officers elected are: President, W. E. Berry, Jonesboro; Vice-president, A. C. Modelevsky, Jonesboro; Secretary-Treasurer, J. H. McCurry, Cash, and Censor, D. H. Kenamer, Marked Tree.

J. H. McCurry, Secretary.

Union County Medical Society has elected the following officers: President, J. H. Pinson, Jr.; Vice-president, A. R. Clowney, and Secretary-Treasurer, J. K. Sheppard.

The Washington County Medical Society was addressed December 6th by Congressman

Trimble. Officers elected are: President, J. W. Dorman; Vice-president, Charles Applegate, Jr., and Secretary-treasurer, Coy C. Kaylor.

The Arkansas Public Health Association was addressed at its meeting in Little Rock December 8th and 9th by A. M. Washburn, "Polio in Arkansas, 1949."

The Ouachita County Medical Society met in dinner session at Camden on Thursday, December 1st, with the following scientific program: "Common Anorectal Conditions," Marion Craig, Little Rock; "Vaginitis," D. D. Wallace, Little Rock.

The following officers for 1950 were elected: President, Henry Hearnberger, Stephens; Vice-President, John P. Thompson, Bearden; Secretary, R. B. Robins, Camden; Delegate, Perry Dalton, Camden; and Alternate, James Guthrie, Camden.

R. B. Robins, Secretary.

Cancer seminars sponsored by the Committee on Cancer Control, Arkansas Medical Society; the Arkansas Division, American Cancer Society and the Arkansas State Cancer Commission, were held during November at Jonesboro, Little Rock, Texarkana and Fort Smith, with the following guest speakers: A. N. Arneson, St. Louis; Ralph F. Bowers, Memphis; Joseph H. Burchenal, New York; Rawley M. Penick, Jr., New Orleans; Henry C. Harrell, Hot Springs, and William O. Russell, Houston.

Lawrence County Medical Society has elected the following officers: President, Ralph Joseph; Vice-president, J. B. Elders; Secretary-treasurer, C. D. Tibbels, and Delegate, J. C. Land.

The Ninth Councilor District Medical Society met in luncheon session at Harrison December 2nd for the following program: "Diagnosis and Treatment of Intravascular Clotting," Carl A. Rosenbaum; "President Trend in Management of Urinary Tract Infection," H. Fay H. Jones, and "Improved Diagnostic Approach to Cancer of the Lung," J. K. Donaldson, all speakers of Little Rock.

J. G. Gladden, Secretary.

"America and the Welfare State" will be the subject of an address by Dr. George S. Benson, Searcy, President of Harding College, at a special all-city meeting to be partially sponsored by the Pulaski County Medical Society on Tuesday,

February 7th, 8:00 p. m., at the Robinson Memorial Auditorium, Little Rock.

Other civic organizations which have volunteered to join in the sponsorship include the Little Rock Chamber of Commerce and the American Legion. All Society members are invited to attend the meeting and bring guests.

Pulaski County Medical Society recently elected the following officers for 1950: President, Daniel H. Autry; President-Elect, Edgar J. Easley; Secretary, Edwin F. Gray, and Treasurer, R. M. Blakely, all of Little Rock.

Sebastian County Medical Society has elected the following officers: President, L. A. Whitaker; Vice-president, Ken Thompson; Treasurer, J. D. Olson; Secretary, M. B. Hoge, and Board of Censors, E. C. Moulton.

The annual neuropsychiatric meeting at the VA Hospital, North Little Rock, Arkansas, for 1950 will be held at that hospital on February 23-24, 1950. A number of nationally known leaders in neuropsychiatry and related fields are expected to participate, including Drs. Walter Alvarez, Daniel Blain, Edwin F. Gildea, Karl Menninger, John N. Rosen, and others. There will be no charge for registration and attendance of all interested professional personnel will be welcomed. Further information may be obtained by writing to the Director of Professional Education, VA Hospital, North Little Rock, Arkansas.

WOMAN'S AUXILIARY NEWS

The Garland County Medical Auxiliary met in November with Mrs. James A. Chestnut, hostess, and Mrs. O. A. Smith, Mrs. Driver Rowland, and Mrs. Frank Adams, co-hostesses.

Mrs. Leeman King, president, presided over a short business meeting. A most interesting program on Cancer Control was given by Dr. E. R. Browning, president of the Garland County Medical Society. Dr. Paul Woods, showed two films on cancer detection. The auxiliary voted to cooperate with the Garland County Medical Society in organizing a cancer education program. The following committee was appointed: Mrs. John Dodson, Mrs. Frank Adams, Mrs. Paul Woods, Mrs. James Leatherman and Mrs. L. O. Bohnen. An announcement was made to bring Christmas gift packages for underprivileged children to the December meeting.

Delicious refreshments were served by the hostesses.

Mrs. L. E. Reed, Secretary.

The Ladies Auxiliary to the Hot Spring County Medical Society met with the doctors for a dinner meeting at the Barlow Hotel on November 8, with Dr. and Mrs. W. F. Barrier as hosts. Dr. and Mrs. Clyde Rogers of Little Rock were guests for the evening.

After dinner we returned to Mrs. Barrier's home and held a short business meeting, after which a social hour was enjoyed.

Mrs. C. R. Ellis, Secretary.

The Pope-Yell County Medical Auxiliary held its regular November meeting in the home of Mrs. Max Mobley. Mrs. Roy S. Millard, President, presided over a short business meeting. The December meeting will be with Mrs. A. Watson.

Mrs. William O. Young, Secretary.

The Ladies Auxiliary to the Washington County Medical Society met with Mrs. P. L. Hathcock on November 29, with 12 members present. During the brief business session it was voted to send contributions to the Else F. Oates Fund, Earle Chambers Memorial Fund, Martha Harding Gann Fund, and to send Hygeia to all schools in Washington County. It was voted to send a Christmas gift package to a family in Germany whose daughter is in University of Arkansas.

The next meeting will be the third Friday in January.

Mrs. P. L. Hathcock, Secretary.

The Ladies Auxiliary to the Craighead-Poinsett County Medical Society met with the doctors on December 7, 1949, for dinner at West Park restaurant. Following the dinner the auxiliary held a short business meeting at which time annual dues were collected from the 12 members present. The ladies then rejoined the doctors to hear Congressman E. C. (Took) Gathings, the guest speaker.

Mrs. Malcolm O. Peeler, Secretary.

The Sebastian County Medical Auxiliary met with our new president, Mrs. Kenneth Thompson. It was voted that we continue our usual contributions to the Elsa F. Oates Fund and the Earle Chambers Memorial Fund.

After discussions, we found that most all our members were involved in some charity work with other organizations, and it was decided to keep our meetings on a social basis, and not try to raise any more money than our dues will bring in.

The Auxiliary met on November 14 with Mrs. Kenneth Thompson presiding as president. Mrs. W. E. Knight was welcomed as a new member.

Plans for the State Medical Convention were discussed. Mrs. Louis K. Hundley, state president, is to be guest speaker at our meeting in January.

Mrs. Ben H. Pride, Secretary.

The Auxiliary to the Ninth Councilor District Medical Society met December 2nd at the Hotel Seville in Harrison for a luncheon meeting with the doctors of the district. Out-of-town guests at the luncheon were Dr. and Mrs. Carl Rosenbaum, Dr. and Mrs. Fay H. Jones and Dr. and Mrs. J. K. Donaldson of Little Rock.

In a business meeting following the luncheon Mrs. H. V. Kirby took over her duties as president of the Auxiliary. New officers elected for the 1950-52 term were: Mrs. J. G. Gladden, president-elect; Mrs. Wm. H. Breit, secretary-treasurer. Committee chairmen were appointed as follows: Program, Mrs. J. G. Gladden; Hygeia, Mrs. A. L. Carter; Public Relations, Mrs. Ulys Jackson; Bulletin, Mrs. A. V. Adams; Doctor's Day, Mrs. Wm. H. Breit; Education and Public Health, Mrs. A. F. Stanley; Legislation, Mrs. J. G. Gladden; Postwar Planning, Mrs. O. B. McCoy; Loans and Funds, Mrs. D. L. Owens; Cancer Control, Mrs. R. E. Fowler; Memorial and Chaplain, Mrs. J. H. Fowler; Organization, Mrs. W. A. Bradley; Courtesy, Mrs. Ulys Jackson.

After the business meeting Mrs. R. E. Fowler held open house for members and guests. Eleven of the 18 members were present.

Mrs. Wm. H. Breit, Secretary.

Mrs. Betty Kinzer, wife of Dr. G. M. Kinzer of Caraway, passed away November 29 at her home in Caraway. Mrs. Kinzer was president of the Craighead-Poinsett County Auxiliary. She was a registered nurse and assisted her husband in operating a clinic. They had just completed a new clinic in Caraway. The Auxiliary regrets the untimely death of Mrs. Kinzer and sends their heartfelt sympathy to the family.

Mrs. Louis K. Hundley of Pine Bluff, President of the Arkansas Medical Auxiliary, was guest speaker at the monthly meeting of The Woman's Auxiliary to the Bowie-Miller County Medical Societies which was held on Thursday, October 27, at the country home of Mrs. C. E. Kitchens. Mesdames Roy Baskett, Ralph Cross, W. L. Kitchens, R. R. Kirkpatrick and Cyrus P. Klein of Texarkana as well as members of the Sevier-Polk

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RESEARCH IN THE SERVICE OF MEDICINE

Counties Auxiliary, Mrs. R. D. Dickenson, president, were co-hostesses.

Mrs. Hundley's talk on Public Relations emphasized that effective personal relations must begin within a group itself and if it is to be effective elsewhere each group must be informed; it must be sold on what it is trying to promote; there must be constant and consistent efforts by each individual member and its service toward a course must be genuine. These points were directed as criteria to be used in the Auxiliary's Crusade against compulsory health insurance. She urged her audience to become familiar with all bills concerning compulsory health insurance and to contact their congressmen and senators urging them to vote against any measure which would enslave any group of American citizens. She asked the group to take an active part in the High School essay contests which have as their purpose the education of the youth to what socialized medicine is and can mean to the American people.

Mrs. Hundley was introduced by Mrs. L. J. Kosminsky, program chairman.

Mrs. A. A. Little, president of the Auxiliary, presided at the business meeting after which a luncheon was served to thirty members and guests.

Mrs. C. P. Klein,
Publicity Secretary.

The Auxiliary to the Fourth Councilor District Medical Society met in Monticello October 17th at the Ridgeway Hotel. After dinner with the doctors, the ladies met in the home of Mrs. Lewis Hyatt. Mrs. L. K. Hundley, State President, explained the Arkansas plan of the essay contest and that each Councilor District is entitled to a prize of a \$100 war bond.

Mrs. J. B. Holder was appointed District Council Woman.

The Christmas Party will be at McGehee.

There were 22 present including two guests, Mrs. Drew Agar and Mrs. Craig.

An enjoyable social followed.

Mrs. Van C. Binns.

BOOK REVIEW

Dr. Colwell's Daily Log for Physicians. Champaign, Illinois: Colwell Publishing Company, 1949. Price \$6.00.

The most satisfactory and complete business record available for the physician.

Atlas of Peripheral Nerve Injuries: By William R. Lyons, Ph.D., Associate Professor of Anatomy, University of California Medical School; and Barnes Woodhall, M.D., Professor of Neurosurgery, Duke Medical School, Durham, N. C. 339 pages. Philadelphia and London: W. B. Saunders Company, 1949. Price \$16.00.

This large atlas is limited to battle wounds and the authors have diligently prepared the 135 plates to illustrate the various types of nerve injuries. Typography is excellent and the work will likely become a classic in its field.

Care of the Surgical Patient—Including Pathologic Physiology and Principles of Diagnosis and Treatment: By Jacob Fine, M.D., Surgeon-in-Chief, Beth Israel Hospital; Professor of Surgery at Beth Israel Hospital, Harvard Medical School. 544 pages with 40 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$8.00.

The author has written a text in concise, simple style which will prove useful and practical to the surgeon.

Operations of General Surgery: By Thomas G. Orr, M.D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas. Second Edition. 890 pages with 1,700 step-by-step illustrations on 721 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$13.50.

A concise, well illustrated, up to date textbook of operative surgery written not only for the beginner in surgery but for the general surgeon as well. It includes many of the newer operative procedures which ordinarily appear only in books of the surgical specialties. The indications for operation have been summarized, and descriptions of the most important operations have been preceded by a section on dangers and safeguards.

Fundamentals of Otolaryngology—A Textbook of Ear, Nose and Throat Diseases: By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology, Director of Division of Otolaryngology, University of Minnesota Medical School, Minneapolis; and Associates—Charles E. Connor, M.D., Anderson C. Hilding, M.D., Jerome A. Hilger, M.D., John J. Hochfilzer, M.D., Conrad J. Holmberg, M.D., Kenneth A. Phelps, M.D., Robert E. Priest, M.D., George M. Tangen, M.D. 443 pages. Philadelphia and London: W. B. Saunders Company, 1949. Price

As a book designed to offer basic instruction to medical students and to provide fundamental information to the physician who is not a specialist, this publication adequately fulfills its purpose. It is well cross-indexed for ready reference in office practice and touches on all the main and allied fields of otolaryngology with discussions which are pertinent but not exhaustive.

The chapters concerning the Physiology of the Nose, Hearing Aids and Allergy are outstandingly good. They will be very useful in improving the quality of the physicians own treatment and give a more exact knowledge of when the patient should be referred to a specialist.

The reviewer notes only two therapeutic methods which he considers undesirable. These are: (1) the use of glass nasal and ear suction tubes and glass cannulae for application of solution to the larynx, (2) the use of Pringle solution in the nose.

FEB 9 - 1950

San Antonio, CO, 2

The JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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The *multiple dietary food supplement* Ovaltine in milk has wide usefulness for enhancing to full adequacy even nutritionally poor diets. Its rich store of vita-

mins and minerals includes vitamins A and D, ascorbic acid, thiamine, riboflavin and niacin, and calcium, iron and phosphorus. Its nutritionally complete protein has excellent biologic rating.

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IRON.....	12 mg.	COPPER.....	0.5 mg.

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NEWER MANAGEMENT OF CARCINOMA OF THE BLADDER

Part I.

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JAMES W. HEADSTREAM, M.D.

Our discussion today is Newer Management of Carcinoma of the Bladder with particular emphasis on management of the infiltrating type and with the more radical approach to the subject.

First, I think it would be well, however, to review a short while on carcinoma of the bladder in general to bring us up to the subject to be presented.

Carcinoma of the urinary bladder is responsible for from $\frac{3}{4}\%$ of the deaths from malignant disease in this country.¹ It seems to be on the increase, as well as carcinoma elsewhere, but this is probably due to the increased facilities for diagnosis. But in the case of bladder tumors industrial expansion may be bringing more people in contact with specific carcinogenic agents.

Carcinoma of the bladder usually begins insiduously, growing for variable periods of time and unless destroyed it progresses rather slowly to a fatal termination. Unfortunately, carcinoma of the bladder occurs more frequently in the active portion of the organ, namely, the trigone, the ureteral orifices, and the vesical neck, and requires more radical approach for eradication of the infiltrating varieties.

Approximately 95% of all bladder neoplasms are epithelial tumors and the remaining 5% are various types of mixed tumors, sarcomas, and unusual types which are chiefly encountered in childhood.² Epithelial growth are rarely seen before adult life and their incidence rises with advancing age.

Jewett conveniently divided these epithelial tumors into two groups—non-infiltrating and infiltrating.³

The benign papilloma has a slender stalk, slender

der villus or finger-like processes and the epithelial cells covering these processes are similar to the transitional epithelium of the bladder wall. The basement membrane under that epithelium is intact.

In papillary carcinoma without infiltration, the stalk is similar to the so-called benign papillomas, but the various stalks are fused together and the lining cells become a little less differentiated.

In papillary carcinoma with infiltration the basement membrane is broken and the cells invade the bladder wall to varying degrees.

Another somewhat different cellular type of infiltrating carcinoma, less commonly seen, is the epidermoid carcinoma which also invades the bladder wall.

Patients often have symptoms so long before they seek relief that the tumor has grown deeply into the prostate, through the bladder wall, and in the female into the vagina. Jewett found that 70% of his series had had symptoms longer than six months, and 50% had had symptoms longer than one year before coming in for treatment.⁴

As we all know, hematuria is one of the earliest and most constant symptoms of carcinoma of the bladder. It is present in approximately 90% of these patients. It is a symptom that is not only too often disregarded by the patient but is often also treated lightly by the doctor. Too often we have seen patients who have consulted their doctor with this symptom, have been given some medicine, and dismissed without further check. Frequently several months lapse before recurrence of the symptom and what might have started as a non-infiltrating papilloma, has since become a deeply infiltrating tumor, making the difference between a cure and a death.

The infiltrating group eventually cause bladder irritability in some form or other, usually due to pyuria.

The diagnosis is based on the cystoscopic appearance of the tumor, and, in questionable cases, by biopsy of the mass. The value of the cystoscopic appearance of the tumor is very important and, along with an estimate of the degree of infiltration, is of greater value than the cellular appearance of the tumor following biopsy

and sections. We have often seen a biopsy show a low grade malignancy, whereas, when the tumor was completely removed, it was found to be highly malignant in the base of the tumor. It has been found that prognosis cannot be made from biopsy alone. The degree of infiltration is a more reliable guide. In 1936 the Carcinoma Registry of the American Urological Association said. Quote: "It is impractical to attempt the segregation of bladder tumors into definite groups corresponding to their cell types."⁵

Dr. Jewett has shown that the incidence of both the metastases and extravesical extension was directly proportional to the depth to which the carcinoma had penetrated the bladder wall.⁶ He separated these into three groups called, A, B, and C. Group A comprised those in which infiltration was limited to the submucosa. Group B composed those in which infiltration extended into, but not through, the muscularis. Group C included cases in which tumor cells has extended through the muscularis completely. In the majority of cases the tumor does not metastasize until it has penetrated deeply into the muscularis. If the basement membrane has not been invaded the tumor is non-infiltrating, and 100% of these cases are theoretically curable. After the tumor has reached the subfacial stage the curability rate drops sharply. The size and distribution of the lymphatics in the bladder wall contribute to this.

The degree of invasion of the bladder wall has a very practical significance in planning the type of treatment. Bimanual examination under anesthesia, both in the male and the female, is a very important part of the examination. It is necessary that the patients have complete relaxation for adequate examination. The infiltrating, stony, or rubbery mass definitely indicates invasion through the bladder wall, and does not lend itself to radical surgery.

Another important point which we would like to emphasize is that in those cases that have had carcinoma of the uterus, either of the cervix or body, so often there is a secondary invasion of the bladder. In many of these cases death is not the result of carcinoma per-se but a result of infiltration of the bladder involving the ureteral orifices with obstruction, resulting in a urosepsis and a kidney death.

Bimanual examination and cystoscopic examination will afford a definite opinion as to the infiltration in these cases.

These cases can be adequately handled by surgery if not allowed to progress too far, as will be brought out later along.

Treatment is divided into three categories: electrical fulguration; radiation; and surgery, which is sub-divided into segmental bladder resection and complete cystectomy.

In benign and malignant papillomas electro-resection and coagulation by the transurethral route, where possible, followed in the malignant cases by application of Radium, usually suffices. When very large and inaccessible these tumors are better treated through the open bladder.

The treatment of the infiltrating group has not been uniformly satisfactory. In 1936 the Carcinoma Registry of the American Urological Association reported that of their cases on file only 13.9% were alive at the end of five years.⁷ But in the last ten years more radical surgery has been directed toward the eradication of the infiltrating type of tumor and although sufficient time has not lapsed for critical evaluation of these cases a marked reduction in both morbidity and mortality is being obtained.

A wide degree of opinions as to the proper management of these infiltrating cases has been listed. They vary from external roentgen therapy, through electro-resection and coagulation, insertion of Radon seeds, segmental resection where possible, and lastly total cystectomy. Proper selection of earlier cases for total cystectomy is producing cures which are not possible through any other procedure.

Failure of any method can be expected if pre-existing extravesicle extension or metastases are present, and complete eradication of the primary growth is not accomplished.

Segmental resection offers as high degree of cure as total cystectomy in those tumors that are accessible. This eliminates the procedure from those tumors that have involved the trigone, ureteral orifices, prostate, or vaginal wall. In these regions certainly diversion of the urinary stream and total cystectomy is the method promising the greater degree of expected cure.

With proper technique in performing total cystectomy a cure may be expected in cases of diffuse, non-infiltrating papillomatosis and in superficially infiltrating tumors which have not yet passed half way through the muscularis.

Conclusions

1. Malignancy of the bladder is one of the most difficult problems with which the urologist is faced.
2. Cure rate depends on the early diagnosis and the medical profession must be hematuria conscious.
3. Transurethral resection either with or with-

out radon seed implantation, as required by the individual case, gives an excellent opportunity for cure in the non-infiltrating or slightly infiltrating cases.

4. Radical segmental resections, where possible, and total cystectomy are offering a higher cure rate in the more infiltrating types.

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Part II.

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The association of general surgeons in the presentation of this subject requires some explanation at the very outset. Carcinoma of the urinary bladder is, of course, a strictly urologic disorder. And it is the urologist only who is capable of proper study and classification of these patients, especially as the selection of ones for cystectomy requires the mature judgment of the urologist familiar with all gradations of bladder tumor. And, of course, the proper evaluation of the upper urinary tract is an essential part of the appraisal. Yet the radical operation of cystectomy often entails a total hysterectomy, possibly a colon resection, and always bi-lateral uretero-sigmoid transplants. It is in the performance of these associated surgical maneuvers that the general surgeons can be helpful.

Drs. Jones and Headstream have already indicated the type of case which can be expected to do so poorly with treatment less radical than that under discussion. The problem of the surgical cure of cancer here is obviously similar to that which we emphasize everywhere. The earlier and less advanced the lesion, the better is the result, and visa versa.

Cystectomy should be offered to patients with carcinoma of the bladder involving the urethra, the ureteral orifices, or the trigone, and with sessile growths over 2 cm. in diameter. This is particularly true if there is involvement of the musculature of the bladder or intractable pain, urgency or bleeding.

The operation of total cystectomy necessitates a diversion of the urinary stream before the removal of the bladder can be undertaken. All workers in this field are agreed that the ureters should be placed in the sigmoid or rectal sigmoid. The transplantation of the urinary stream into the skin is intolerable to most patients and is only a poor second choice, used in cases of extreme necessity. It is upon the method of ureteral colic anastomosis that argument arises and upon its late results that mortality of this operation largely falls, due to ascending infection.

There have been numerous methods suggested for the technique of ureteral colic anastomosis. These are in general of two types, the open or the closed method. A classical example of the first or open method is the Coffee operation. This consists of severing the distal end of the ureter and implanting it into a hole in the bowel through a tunnel of serosa. The closed method which Coffee later employed and which Jewett now recommends, entails implantation of the uncut ureter into the wall of the bowel. At a later time a perforation of the wall of the bowel and of the ureter is made and the ureter severed. This two-stage procedure is said to have the advantages of sterility and a gradual approach to the matter. The technical details are of great importance to the operating surgeon but need little discussion here. We believe that the simpler, more direct, open method is easier, surer, and productive of better end results. The complicated variations of the closed method work well in the hands of men accustomed to their own unique methods, but with chemotherapy and operative technique at its present level the open anastomosis can be quickly and surely carried out without contamination, without infection, and without subsequent stricture.

The removal of the bladder must next be undertaken and the combined perineal abdominal method is attractive as it is more direct and more radical. One may vary the approach at this stage with the location of the tumor.

The entire operative gamut can be done in one, two or three stages. Certainly implantation of one ureter at a time is more cautious than bi-lateral implantation and cystectomy in one stage,

but the two-stage procedure seems a fair compromise and gets the patient out of the hospital in three weeks.

The technical details of operation can be obtained from numerous articles, but we would like to present a few points which are of especial importance.

In the first place it is highly desirable that the ureter be of normal size and resiliency. A ureter enlarged and stiffened by periureteritis can be transplanted only with difficulty and with added risk of immediate and late complications. If both ureters are seriously involved in this respect it really constitutes a contra-indication to operation.

After the abdomen is first opened, one needs to do a general exploration. If extension of tumor to distant parts exists or if local extension is beyond the limits of resection one must be prepared to abandon the operation. We have had one experience of this type.

We have found it satisfactory to operate first through a low mid-line incision. It is definitely advantageous to transplant the left ureter first and at a level which will be higher than that to be used for the right ureter later. It is wise to be sure that the sigmoid below this first anastomosis will come over nicely to the region of the right ureter. While both ureters may be transplanted at one sitting and in fact the whole procedure done at one time, we are of the definite opinion that the best method is to perform only the left uretero-sigmoid transplant at the first operation. Swelling and temporary occlusion is much better in one ureter rather than both. This anastomosis is then placed retro-peritoneally and the working incision closed without drainage.

We have had no infection following the first stage, so that the second is done one week following the first. We have approached this whole procedure with great caution and have done some cases in three stages. In such event the mid-line incision is reopened, the right ureter transplanted, and the wound closed with through and through heavy silver or steel wire. Another week then must elapse before the third stage. Such caution is probably unnecessary in patients whose condition is good. The final operation is done in either event through a low transverse incision just above the pubis, but with both ends curved upward. And the right ureter and cystectomy can then be done at the second operation. In making the uretero-sigmoid transplant it is helpful to place four superficial sutures in the sigmoid in order to flatten out and hold up a

rectangular area of about 2 by 5 cm. A 4 cm. longitudinal incision down to but not into mucosa is then made in this area between longitudinal bands. The mucosa is then pierced at the most distal point of this trough. A fine catgut suture is made to enter the bowel through all layers about 1½ cm. further down, to come out the incision, grasp the edge of ureter and retrace the path in order to draw the ureter down into bowel and fix it there. It is wise to enlarge the opening of the ureter by making a 1 cm. longitudinal incision up from the cut end. The submucosa and muscularis are then covered over the ureter with fine catgut and serosa in a second layer of fine cotton.

The removal of the bladder presents no special difficulties except that it is fragile and tends to tear. In women patients one will usually find that the region of the base of the cervix is involved with tumor and in each of our cases it was necessary to remove the entire uterus and vault of vagina. One has the unique comfort here of not having the usual concern about ureters. The lower stump of ureters are easily removed. In men it is necessary to remove prostate and usually the vesicles.

In many patients one will need to go below and remove the urethra with the specimen of bladder. In some cases this is not necessary. Drainage of the bladder area is advisable in closing this wound.

It is debatable as to whether one should ever perform uretero-colic transplants in a patient who has a colostomy. Certainly the escape of urine through a colostomy is a miserable state of affairs and we cannot recommend it.

Dr. Jones has mentioned a further situation upon which I would like to speculate. Numerous patients who have carcinoma of the cervix die of uraemia incident to low ureteral occlusion by tumor. In most cases these patients have extension elsewhere and nothing need be done. In a few, however, palliation might well be considered in the form of uretero-colic transplants. Of course, it would be impossible to remove such an invasive tumor.

Our experience with uretero-sigmoid transplants in benign conditions utilizing the procedure described has been most happy and with no mortality and only minor urinary tract infection. These have been done for extrophy of the bladder, intractable scarring of the urethra, recurrent severe vesico-vaginal fistula, intractable cystitis, etc. These patients have no passage of urine at night and average about four times per day.

Our experience with cystectomy for carcinoma of the bladder has been limited to six cases. Two of these were done in the Army and with good immediate results. They were done in association with Dr. Leander P. Riba, of Chicago. I do not have any late follow up on these two cases. The other four were done in association with Dr. Jones, one being referred by Dr. King Wade. The details of these are given below. One woman is quite well and happy after one year. Another woman who had a particularly extensive tumor is well after six months. Our third woman died after one year with a solitary metastasis to adrenal. One man died following the third stage. In this case we pushed the limits of operability too far as he had only one functioning kidney and that a poor one. He died of uraemia.

This is by no means a brilliant and certainly not a large series of cases. We have no intention of presenting it as such. The period of follow up is short. But we are convinced that the method of procedure is satisfactory, that the operations are not unduly radical, and that with early tumors some highly gratifying results may be obtained.

CASE REPORTS

1. S. A. was a 42-year-old white female with a history of severe pain in the bladder and gross hematuris from advanced papillary cystadenocarcinoma of the bladder. She tolerated a total cystectomy well and was symptom free for 9 months. Extreme weakness then developed and she died two months later. Autopsy revealed only a solitary metastasis to one adrenal.

2. Mrs. L. V., 37-year-old white woman with hematuria for two and one-half years from a carcinoma of the bladder involving the bladder neck and vagina. In August, 1948, a bi-lateral ureteral colic anastomosis was done and 10 days later a total cystectomy with removal of the uterus, cervix, and entire anterior vaginal wall. Her convalescence was uneventful and she has been well since.

3. I. E., 62-year-old white man was admitted with dysuria and nocturia of many years duration from a carcinoma involving the entire bladder. He had very poor kidney function on the right side and none on the left. N. P. N. was 77. His general condition was very poor. He was bleeding continuously and in torment. Because of these two circumstances he was accepted for operation and survived the first two stages, but died following the last with an N.P.N. of 300. Postmortem examination was obtained and showed a chronic interstitial nephritis with a completely contracted kidney on the left and an advanced stage of the disease on the right. It was felt that both these conditions preceded his operative experience by a considerable period of time. It must be admitted that the limits of operability were obviously stretched in this case, but pain, disability, and loss of blood forced the surgeon's hand.

4. Mrs. E. H. M., 53-year-old white female, was seen with a two months history of hematuria from an epidermoid carcinoma of the bladder. In May, 1948, a ureteral colic anastomosis and total cystectomy was done. She has been well since.

PUERPERAL GYNECOLOGY L. THE IMMEDIATE REPAIR OF CERVICAL LACERATIONS AT CHILDBIRTH*

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The number of hospital admissions for the repair of obstetrical injuries to the soft parts of the female pelvis is high. With the spotlight directed upon the economics of medicine, it seems that more effort should be made to prevent these injuries at childbirth or if possible to repair the injury at the time the patient is being hospitalized for childbirth.

The adoption of sound obstetrical principles by a large number of physicians, who include obstetrics in their practice, is already decreasing the number of cases admitted to hospitals for the repair of cystoceles, procedentia and rectoceles. These principles include the general use of the episiotomy, refraining from the use of high forceps or manual cervical dilatation, and not allowing patients to experience prolonged labor. There are however no carefully formulated or advocated principles regarding the care of cervical lacerations which occur at childbirth. Reports on the incidence of cervical damage at childbirth vary, but have been quoted as occurring in as high as 80% of deliveries.¹ The lack of adequate facilities in the delivery room and the necessity of prolonging the anesthetic have been the factors considered responsible for neglecting complete cervical inspection and repair. As a result, hemorrhage has been considered by many as the only criteria for inspecting the cervix and effecting its repair.

Realizing that lacerations and subsequent infections exist among a very high percent of patients seen in practice, we have attempted to ascertain the number of these lacerations that occur at childbirth, and to work out some principles for their care, that would be acceptable to the large number of practitioners who do obstetrics.

One thousand consecutive private patients were subjected to a careful inspection of the cervix and criteria of repair were formulated from personal observations as well as observation of others. These cases were delivered in three hospitals located in towns of twenty to sixty thousand. Anesthesia used included several

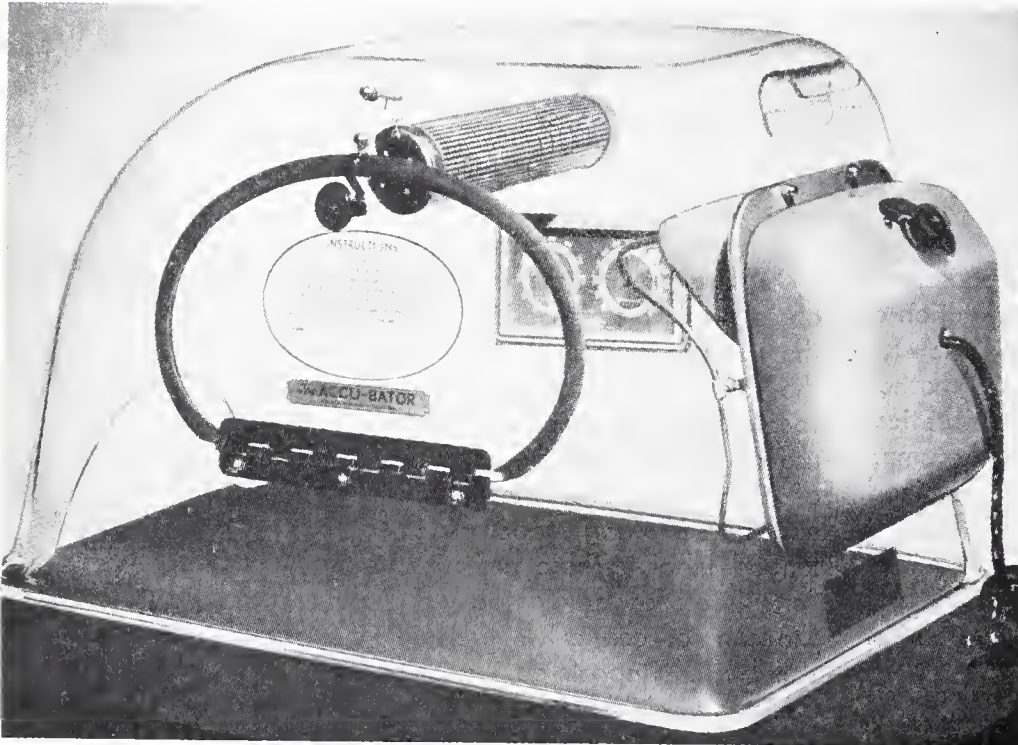
*Read before the Seventy-third Annual Session, Arkansas Medical Society, Little Rock, April 14, 1949.

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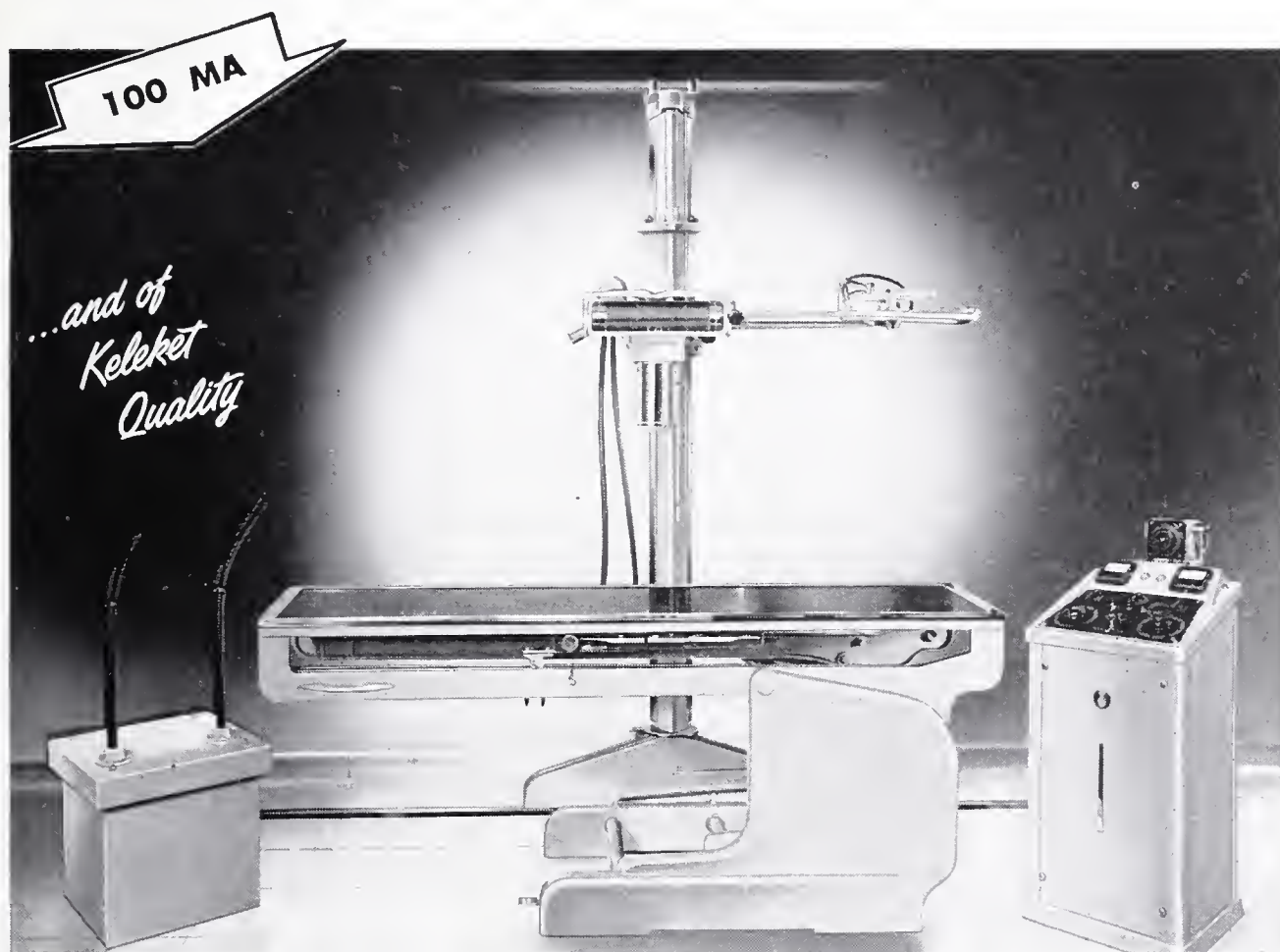
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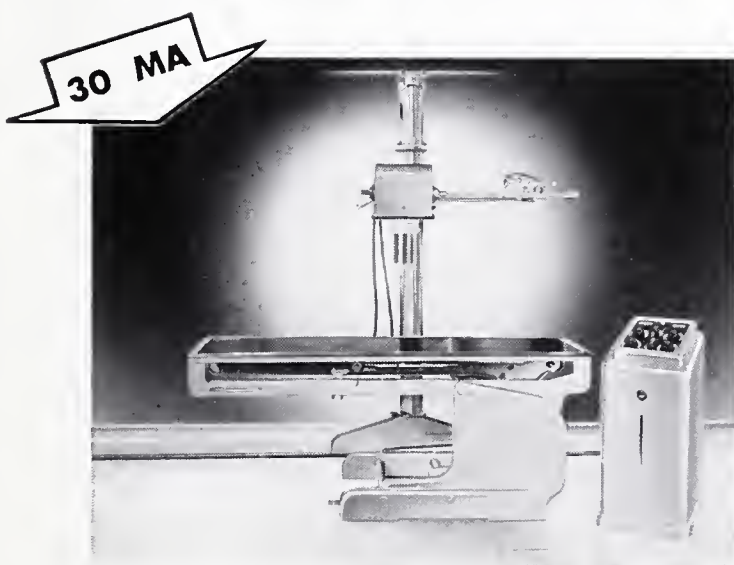


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types of inhalation anesthetics, caudal, regional spinal and local infiltration. No assistant was present except occasionally a student nurse would scrub for delivery. As the series advanced several criteria were adopted from experience which seemed to further justify the wisdom of these procedures. While universally some cervical injury was noted, 35% of the cases were considered as being torn deeply enough to warrant repair. All cases were repaired where the injury penetrated the cervix for one or more centimeters. Approximately 25% of the cases had tears of 2 cms. or more and an appreciable number had bilateral tears. As is reported by others, most tears occurred at the outer and lower aspects of the cervix corresponding to 4 and 8 on the clock dial. There when the forceps had been used in the midplain of the pelvis or for a forcep rotation were usually tears. However many deep lacerations occurred in spontaneous deliveries or subsequent to episiotomy in primipara. Some of the most severe lacerations occurred in cases of premature births. When the lack of the preliminary thinning of the lower uterine segment and the cervix which occurs in the final months of pregnancy is considered, in these cases a rational for the high incidence of tears in these cases is evident. We are led to believe that this is due to labor occurring before the lower uterine segment and the cervix have become thinned and to the state seen in firm delivery. Old lacerations, or those existing from previous confinements were repaired when feasible by denuding the mucosa over the tear and carefully approximating the original cervical edges. Some of the cases gave evidence, when reapproximated, that practically no dilatation of the cervix had ever occurred.

Bleeding from cervical tears of alarming nature constituted less than 1% of the cases indicating to us that hemorrhage is no criteria of the number of cervical injuries.

The technique of repair varied considerably, but in general small tears were simply sutured with fine chromic catgut in a continuous manner, while larger tears required individual sutures. The cervix was exposed by the use of gelpi and ribbon retractors, the latter often held by a non-sterile attendant grasping the retractors through two thicknesses of sterile drapes. The cervix was grasped with sponge forceps and all sections of the cervix were exposed by pulling it to the vaginal outlet. Repair was made by holding both sponge forceps in one hand and sewing the edges with the free hand. If any questions of too much or too long an anesthesia existed a

local infiltration of the pudental nerve area was carried out and all other anesthesia stopped. This proved so successful that it has become our universal practice to infiltrate the pudental nerve area before delivery takes place and to discontinue all inhalation anesthesia as soon as the baby is born. The cervix can then be inspected and the episiotomy repaired without further danger to the patient.

Following the inspection and repair of these cases, no average increase of the usual one week prewar hospitalization or of the postwar three-day hospitalization occurred. Considering the many factors involved in morbidity studies, it is impossible to accurately estimate the morbidity due to this procedure. There was however no over all morbidity increase in this series of 1,000 cases.

At 6 weeks postpartum examination, 85% of the cases were considered as having benefitted by the procedure and an additional 10% responded to minor office procedures. Five per cent were considered as being poor results and represented cases which were subsequently hospitalized or advised to have plastic repair at a later date.

The economic values of these repairs become apparent when one considers that a high percent of physicians time is taken up with gynecological care of the cervix. It is not enough for the specialist to do good prophylactic care of the cervix since he delivers only a small percentage of the children in this section of the country. It is however, his duty to bring the attention of the practitioner who continue to do the majority of obstetrics, the value and simplicity of immediate cervical repair. Our series of a thousand cases over a 4-year period confirm the value of these repairs, and establish simple criteria for the repair of the cervix at childbirth without endangering the patient in any way.

Conclusions

1. The inspection and repair of cervical laceration at childbirth will prevent many subsequent hospital admission for gynecological repair.

2. The use of local anesthesia in the form of pudental block, makes it unnecessary to endanger the obstetrical patient by prolonged anesthesia for repair.

3. 1,000 cases have been inspected and 350 repairs carried out, using local anesthesia, in the majority of the cases for the repair of the cervix.

4. Hemorrhage is no indication of the number of cervical lacerations that occur, as it occurred rarely among the lacerations encountered.

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Ninth District—D. L. OWENSHarrison
Tenth District—FOUNT RICHARDSONFayetteville

EDITORIAL

A ONE-SENTENCE EDITORIAL

Medical care must be made more readily
available: too many of our public servants in
Washington have to go to Bethesda, Maryland,
for professional services.

INTERIM SESSION, AMERICAN MEDICAL
ASSOCIATION, 1949

There were 3,942 physicians registered at the
first three days of the interim session of the
American Medical Association held in Washing-
ton, D. C., December 6-9th, 1949. In addition
to the scientific presentations which were de-
signed for the interest of the general practi-
tioner, the usual interesting scientific and tech-
nical exhibits attracted attention of those pres-
ent.

The most important action of the House of
Delegates was approval of a requirement that
members pay \$25 annual dues for 1950, the first
time in its history that the American Medical

Association has charged membership dues. No
change was made in the provisions regarding
fellowship. In order to be a Fellow, a physician
must first be a member in good standing of
the American Medical Association (a dues-
paying member) and must pay the fellowship
dues of \$12 direct to the American Medical
Association. The reasons for this action have
been previously published in **The Journal**. The
House of Delegates registered specific oppo-
sition to national legislative bills, S. 1453 and
S. 1411. The National Education Campaign
Committee reported that 1,829 organizations
have taken action against compulsory health
insurance. New committees to study the prob-
lem of hospitalization of veterans with non-serv-
ice connected disabilities and to study proposed
national legislation were formed. Arkansas dele-
gates, R. B. Robins and Jos. F. Shuffield, took
an active part in the work of the House of
Delegates.

The outstanding social event of the session
was the reception given by the Arkansas Medical
Society December 5th honoring T. E. Rhine,
Thornton, "Arkansas' Physician of the Year," and
distinguished Arkansans in Washington. The
entire official body of the House of Delegates
of the American Medical Association, the of-
ficers, and distinguished persons in governmental
circles attended this function.

1950—MEDICINE'S ARMAGEDDON

American medicine, during 1949, became a
well-organized, powerful fighting force for free-
dom. It met its enemies, in spectacular contest
before the people, and its enemies gave ground.
At the 1949 session of Congress, the fight for
Compulsory Health Insurance was abandoned,
even though The White House itself had be-
come a sounding board for the socializers.

We have come a long way in a short time.
American medicine is stronger today than at any
other time in its history, bulwarked by the sup-
port of hundreds of other groups and millions
of aroused citizens. But we would be foolish,
indeed, if we assumed that the final victory had
been won.

The advocates of socialized medicine, at the
start of 1949, were in full cry. American medi-
cine was under violent attack from those who
would destroy it, or reorganize it as a political
arm of the government. Medicine's critics, at
the moment, are falling back, waiting for public
vigilance to relax—and hoping that American

doctors will tire of the battle and let their guard down.

But the Battle of Armageddon—the decisive struggle which may determine not only medicine's fate but whether state socialism is to engulf all America—is still ahead of us. That fight may be lost or won in next year's Congress, or in the 1950 congressional elections.

The strategy of our A.M.A. National Education Campaign—and the conduct of that campaign—have been sound. Even the tactics of our enemies are grudging admission of it. The tide of battle actually turned when American doctors, to the astonishment of their critics, refused to turn away from controversy—and, instead, embraced it as a means of getting the facts before the people. We are on the defensive no longer; we are conducting a hard-hitting, affirmative campaign—and we must maintain that offensive.

American medicine's fight will not be completely won until we have mobilized overwhelming support from the American public—and until we have provided the vast majority of the people with sound Voluntary Health Insurance. We have made tremendous strides toward both goals. More than 61,000,000 people now are enrolled in hundreds of competing Voluntary Health Insurance systems throughout the Nation. But we must help to improve and extend the benefits under these systems, as well as expand their memberships.

Let's reach our objectives in 1950. Let's face our Battle of Armageddon, proud to carry the banner for American medicine—and our American way of life.

Elmer L. Henderson, M.D.,
Chairman of the Coordinating
Committee,
National Education Campaign,
American Medical Association.

IT'S YOUR JOB, TOO

It seems unreasonable to note that some physicians exhibit an alarming indifference and apathy toward trends which will abolish the private practice of medicine and are moving toward a socialistic state in America. The fight against these measures has been carried by altogether too few conscientious members of the medical profession. The viewpoint of those who do not eagerly serve to refute the arguments advanced

for government-directed medicine and for steps which would make of American government a travesty can not be understood by those who are giving time and effort in the cause of government by right of the governed. There is pressing need to inspire our people to exercise their initiative and to preserve their independence.

It is the solemn duty of each physician, as a citizen, to give the necessary time and effort to this cause. The pressure of work elsewhere must be secondary.

With your help, it can and will be done.

EDITORIAL COMMENT

MR. STASSEN SAYS: "NEVER! NEVER! NEVER!"

Must reading for physicians and their patients is the article, "Never! Never! Never!" by Harold E. Stassen, president of the University of Pennsylvania, appearing in the January, 1950, issue of Reader's Digest. From a sincere investigation, Mr. Stassen gives his positive opinion that "the British program of National Health has resulted in more medical care of a lower quality for more people at higher cost." This is in marked contrast to the jubilant praise given the system by Oscar Ewing.

AMBULANCE TRANSPORTATION OF INDIGENT CANCER PATIENTS

The Arkansas Division, American Cancer Society, announces that funds will not be available for ambulance transportation of indigent patients effective February 1, 1950.

S. 1411

Senate Bill 1411, known as the School Health Services Act, has been consistently opposed by this Society. The Senate has passed this legislation which would provide medical care to the 29,000,000 school children in this country between the ages of 5 and 17. To this number would annually be added the normal increase in school enrollment, probably 2,500,000 children. Should this bill pass the House of Representatives and become a law, who would direct the health care of this large segment of the population? From whose pockets would the moneys come to pay for this extravagant expenditure of funds by the Federal government?

Successful opposition to enactment of this legislation rests with the citizens of America, intelligently advised by their physicians. Are you doing your part?

CORRECTION

Dr. William A. Reilly, Little Rock, asks that notice be given of an error occurring in his article, "Diagnosis and Present Treatment of Pyogenic Meningitides," upper right hand column, page 140, January, 1950, issue of The Journal of the Arkansas Medical Society. The sentence reading: "The oral dose is 2 to 3 **grams** per pound for the first 24 hours," should read: "The oral dose is 2 to 3 **grains** per pound for the first 24 hours." This error appeared in the manuscript submitted for publication.

RANDOM THOUGHTS OF THE SECRETARY

December 25th. On this birthday of a humble man, whose life gave men more hope and kindness than any other life ever lived, let us take inspiration to live kindly and in harmony with those about us.

January 2nd. By the new "Southern Belle" to Kansas City this morning, visiting Lockwood in his stimulating X-ray conference, and homeward in the early evening, this being railroad travel as it should be, the time required being only about twice that of the plane flight.

January 7th. Across the Panhandle by Braniff with Charles Henry, who is less eager for air travel than once upon a time, joining with Blasingame, Glen and Wright at Amarillo to form, for purposes of mutual interest, Flight 54 Medical Society, an organization which disbands at Stapleton Field, Denver, to a favorite hotel, the Brown Palace, where the staff books us in a 5-room suite so elegant that we charge the Oklahoma delegation two-bits for a look.

January 8th. With interested physicians in conference, each eager to bestir nationwide interest in the fight which should be the immediate objective of many a medical man who now views these disturbed times with apathy and indifference, departing with the hope that today's action will receive hearty cooperative effort across the country.

January 9th. Returning we find "THREE-H" Hundley a guest at our house, bringing the excitement which ever attends her visit, and the Auxiliary business transacted, the Ken Thompsons entertain with tape recordings, display their silver bottle opener, present us belatedly with our Christmas gift from Pere Hinton up Springdale way and thence to Luke Smiths over in Crawford County for good food.

January 13th. This being that unlucky day, avoid walking under ladders, breaking mirrors and black cats—the life you save may be your own.

January 15th. Prior to the Council session at coffee with Madam President of the Auxiliary but promptly interrupted by her husband . . . the council meets and transacts business with dispatch and enthusiasm, one of its best meetings . . . adjourning we heed the admonitions of Earle Hunt over flying in bad weather and this time we pay our way by driving his own car to Clarksville with Richardson and thence homeward on the Missouri Pacific noting that train No. 124 has a wonderfully new coach.

OBITUARY

RUBE CROW KENNERLY, aged 70, died at Camden July 31, 1949. Born January 22, 1879, in Independence county, he graduated from the College of Physicians and Surgeons, Little Rock, in 1909, and located in south Arkansas, practicing at Bearden and other communities in Ouachita, Dallas and Calhoun counties. He assisted in forming the Ouachita County Health Unit in 1928, was the first county health officer in that county and had held office as district health officer for many years prior to his death. He was a member of the Ouachita County Medical Society, of the Arkansas Medical Society and of the Masonic bodies and the Methodist church. Surviving relatives are his wife and two sons.

DON W. DYKSTRA, age 44 years, Little Rock, died in the crash of an airplane piloted by him near Novinger, Missouri, December 31, 1949. A graduate of the University of Iowa and of University of Arkansas School of Medicine in 1936, he received his master's degree in public health from John Hopkins University School of Medicine. His internship was served at Mercy Hospital in Des Moines, and following post-graduate study at Vanderbilt University School of Medicine, he served as public health officer at Morrilton and subsequently joined the Arkansas State Board of Health and venereal disease control officer, a post he relinquished to enter the Naval Medical Corps in 1942. In addition to his membership in the Pulaski County Medical Society, the Arkansas Medical Society, and the American Legion, he was a member of the Masonic bodies and had been installed the week prior to his death as worthy patron of Esther Chapter No. 217, Order of the Eastern Star. Surviving relatives are his wife and a daughter.

EDWARD PELHAM McGEHEE, SR., age 80 years, Lake Village, died January 9. A graduate of the University of Alabama School of Medicine in 1894 he located at Lake Village a few years after graduation and founded the Lake Village Infirmary. He was awarded the 50-Year Club Pin during the 1949 annual session of the Society. Surviving are his son and two daughters.

JESSE SAMUEL RINEHART, age 81, Camden, died January 8 after a prolonged illness

which forced his retirement from active practice. Born in Union, Ohio, he graduated from the University of Illinois College of Medicine in 1900. He was a past-president and charter member of the Ouachita County Medical Society, a honorary member of the Arkansas Medical Society, an affiliate fellow of the American Medical Association, a former chief of staff of the Camden Hospital, and had served medical organizations in many offices during his active practice. In 1947 a celebration was held at Camden honoring his fifty years of practice and the 50-Year Club membership was conferred upon him at the initial presentation of these memberships at the 1949 annual session of the Society. Surviving are his wife, a son and a daughter.

ORAN DOUGLAS WARD, age 74 years, England, died December 12, 1949. Born at Searcy, December 18, 1874, he received his education in the public schools and at Searcy Military Academy, graduating from the University of Nashville Medical Department in 1902. He was an honorary member of the Lonoke County Medical Society and of the Arkansas Medical Society, and had served his county society in the various offices, holding the post of secretary-treasurer for many years prior to his death. He served a four-year term as a member of The State Medical Board of the Arkansas Medical Society. He was an honorary member of England Lodge No. 507, F. & A. M., and a member of the First Methodist Church Board of Stewards. Surviving relatives are his wife and a daughter.



PROCEEDINGS OF SOCIETIES

A postgraduate pediatric conference will be given at the University of Arkansas School of Medicine March 15th and 16th, 1950, under direction of the department of pediatrics with Joseph Stokes, University of Pennsylvania, and George Piness, University of Southern California, as guest speakers. All interested physicians are invited to attend. No fees will be charged.

The American Goiter Association will meet at the Shamrock Hotel, Houston, March 9-11, 1950, with a program consisting of papers dealing with goiter and other diseases of the thyroid gland dry clinics and demonstrations.

The Pulaski County Medical Society met January 9th with a urological symposium as the scientific program. Speakers were: H. Fay H. Jones, G. W. Reagan, T. Duel Brown, John N. Roberts, John W. Headstream and O. C. Melson.

Edwin F. Gray, Secretary.

Faulkner County Medical Society has elected the following officers: President, Keller Lieblong; Vice-president, Tom Mabry; Secretary-treasurer, R. L. Taylor, and Censor, C. H. Dickerson.

Boone County Medical Society has elected the following officers: President, W. H. Briet; Vice-president, C. G. Pierce; Secretary-treasurer, H. V. Kirby; Delegate, J. G. Gladden, and Alternate, Ulys Jackson.

Craighead-Poinsett County Medical Society met in Jonesboro on January 11th with the following scientific program: "Interpretation of Pain," Lyle Motley, Memphis, and "Use of Anti-coagulants in Cardio-Vascular Disease," W. W. Taylor, Memphis.

J. H. McCurry, Secretary.

Stanley Truman, president of the American Academy of General Practice, will address a dinner session of the Arkansas Chapter, to be held at the Grim Hotel, Texarkana, February 24th, at 6:30 P. M. All members of the Society are invited to attend. Reservations should be made with Dr. Noble Daniel, care Grim Hotel, Texarkana.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

"HOW can we provide effective nursing care in tuberculosis sanatoria?" World War II, with its accompanying dislocation in medical and nursing services, focused attention sharply upon the problem of general nursing and tuberculosis nursing in particular. It is time to review these problems in the light of postwar conditions and the circumstances which may be expected to arise in years to come.

EFFECTIVE NURSING CARE FOR THE TUBERCULOSIS

Throughout the field of nursing there is a deficit of workers, and nursing needs have increased in spite of lower death rates, longer life expectancies, and a healthier population. The increase in population, with more people in older age groups, the higher standards of living, and the expansion of medical prepayment plans, have swelled the demand for hospital beds.

An acute deficit of nurses exists in the field of tuberculosis which still accounts for more than 5 per cent of all the days spent in hospitals in this country. In 1948, more than five thousand graduate nurses, and almost twice as many non-professional auxiliaries were employed to care for patients with tuberculosis.

Unfortunately, many hospitals are so badly understaffed that nurses cannot give time to the niceties of care. Tuberculosis, because it is chronic and communicable, is a serious dislocation in the life of a patient. In addition to medical treatment, a patient in a hospital needs to have a sense of being cared for without strain and worry, but today, a nurse is often too rushed to give the care which will foster this sense. If the pressure and haste, the mechanization of nursing, can be eliminated, many more young women will wish to enter the profession.

In tuberculosis hospitals, the nurse is likely to be even more pressed for time than in general hospitals. The recommended standards for nursing services in tuberculosis hospitals has long been the following: 3.3 bedside nursing hours per 24 hours per bed-surgical patient; 2.7 bed-

side nursing hours per bed-medical patient; 1.5 bedside nursing hours per semi-ambulant patient; 0.5 bedside nursing hours per ambulant patient. In practice, almost no tuberculosis hospital has been able to employ enough nurses to meet such a standard.

One source of a nurse's satisfaction in her work has always been the sense of sharing the scientific understanding and confidence of the doctor in the treatment of the patient. The doctor who makes the nurse a member of the medical team, who gives her respect and consideration, who is aware of her contribution, and gives her recognition, helps to make nursing a more attractive profession.

Salary is not the nurse's primary consideration. Yet it should be mentioned that nurses' salaries have not risen in relation to the cost of living, and tuberculosis hospital salaries have not kept pace with gradual increases in salary scale in general hospitals.

A more careful observance of safe techniques in guarding tuberculosis nurses against infection will undoubtedly attract more women to this branch of nursing. Before being assigned to a tuberculosis service, a nurse should have a general physical examination, a chest X-ray, and a tuberculin test. Each of these procedures should be repeated at intervals. Many authorities also recommend BCG vaccination for nonreactors to tuberculin. But few tuberculosis hospitals give nurses routine preemployment physical examinations, and some even omit tuberculin tests, although preemployment X-ray is almost universal.

Effective Nursing Care for the Tuberculosis, Chesley Bush, M. D., Esta H. McNett, R. N., B. S., Lucile Petry, M. A. and Martha B. Naylor, R. N., B. S., Public Health Reports, August 5, 1949.

Nurses assigned to tuberculosis services after passing a physical examination with a chest X-ray, must be protected on the job. Wherever better

care of tuberculous patients has been demonstrated, and better protection for workers has been made easily accessible, it has become easier to recruit and retain personnel.

Improvements in recreation and transportation can also help to increase the inducements of tuberculosis nursing. The trend toward building new tuberculosis wings and hospitals close to general medical facilities will undoubtedly make it possible for additional nurses to enter tuberculosis nursing.

More students will also enter tuberculosis nursing if they receive better instruction and are provided with a safer environment in which to practice. In 1946, only 24 per cent of all schools of nursing offered clinical experience in tuberculosis.

There is an increasing acceptance of minority groups and of men in nursing schools and in the profession. If tuberculosis nursing is made attractive enough, it will draw its share of both sexes and from minority groups.

Up to now there has been almost no systematic analysis of the jobs to be done in a tuberculosis hospital. The present haphazard job "system," with overlapping duties for graduate nurses, practical nurses, aides and orderlies, leads to inefficiency. **Job analyses are urgently needed.** Every hospital should try to use the talents and training of its workers as efficiently as possible.

What then can be done to increase the number of nurses for tuberculosis nursing services in the United States? As has been pointed out, many positive steps can be taken: increasing job satisfaction, better precautions against infection, better instruction of nurses and auxiliaries in tuberculosis nursing, salary adjustments, better hours, increased employment of members of minority groups, job analyses, better utilization of time.

Although it is not inevitable that nursing care will become better as the number of nurses increases, yet the quantity of nurses is considered one index of the quality of patient care. If our society can provide enough nurses to staff its hospitals adequately, each nurse will strive to give the kind of patient care for which she has dedicated herself to her profession. Tuberculosis hospitals, if they keep pace with developments, will share in the improvement of nursing services everywhere.

PERSONALS AND NEWS ITEMS

"Some Aspects of National Medicine," the chairman's address to the Section on Proctology, Southern Medical Association, appeared in the January Southern Medical Journal.

R. B. Robins, Texarkana, addressed the Texarkana Junior Chamber of Commerce recently on socialistic trends in government.

Paul L. Mahoney, Little Rock, attended the recent session of the Southern and Midwestern sections of the American Triological Society in Memphis.

The following have been appointed part-time clinicians with the Arkansas State Board of Health: John H. Miller, Ouachita County; H. E. Mobley, Conway County, and Byron Z. Binns, Chicot County.

R. B. Robins, Camden, addressed the annual session of the Dallas, Texas, County Medical Society January 12th on "The Months Ahead."

John E. Laman has been appointed city health officer at Little Rock.

W. T. Hill, Gurdon, has been appointed commanding officer, Medical Detachment, 308th Heavy Tank Battalion, a reserve unit.

"The Etiological Significance of Contrast Media in Post Lobotomy Complications" by V. Earl Parsons, Jr., Little Rock, appeared in the November, 1949, issue of Diseases of the Nervous System.

Ray Fulmer has been elected president of the Little Rock Junior College Alumni Association.

E. J. Horner has been elected chef de gare of the Jonesboro voiture, Forty and Eight.

The following named surgeons from Arkansas were made Fellows and Associate Fellows in the United States Chapter, International College of Surgeons, at the Convocation ceremonies held during the Fourteenth Annual Assembly of the College in Atlantic City, New Jersey, November 7-11, 1949.

Certified Fellows:

Richard L. Daniel, Hot Springs,
Will Hugh Mock, Prairie Grove;

Advanced to Rank of Certified Fellow:

Dewell Gann, Benton,
James Gossett Martindale, Hope,
Howard Seymour Stern, Pine Bluff; and

Associates:

John L. Aday, Little Rock,
Raymond Mundt, Fort Smith.

In attendance at the Chicago session of the American Academy of Dermatology and Syphilology were D. W. Goldstein, Fort Smith; Dorothy Goetze, Hot Springs National Park, and Ray Fulmer and Ellis Cope, Little Rock.

T. H. Jones has returned from Seminole, Oklahoma to Waldo for practice.

WOMAN'S AUXILIARY NEWS

On December 21, 1949, the Pulaski County Medical Auxiliary met at the Junior League House for its luncheon and Christmas program. It was a very pretty Christmas setting with poinsettias, red candles, sprigs of fir, cedar and holly. Hostesses for the meeting were: Mrs. Robert D. Jones, Mrs. Ray Fulmer, Mrs. Raymond Cook, Mrs. A. J. Brizzolara, Jr., Mrs. Edwin F. Gray and Mrs. Gordon P. Oates.

The Auxiliary is sponsoring the Polio Queen, Miss Delores Robinson, who was the Auxiliary's guest on this day. Miss Robinson gave a short talk about herself and how she had benefited from the Polio Fund. Guest, Mrs. Ida Wills Rudd, gave the invocation and told a Christmas story. The Little Rock High School a-cappella choir, under the direction of Mrs. Dewey Thompson, gave a program of Christmas music. There are sixty members of this choir.

Mrs. Gordon P. Oates,
Publicity Secretary.

Mrs. Gordon P. Oates, Chairman of Exhibits, set up a booth in the Marion Hotel during the Federal Farm Bureau Convention, November 21 and 22, to distribute anti-socialized medicine literature. It was manned by eight women of the Pulaski County Medical Auxiliary. Twenty-five hundred pieces of literature were distributed with very good results.

The Pulaski County Medical Auxiliary will meet at the Junior League House for a luncheon and business meeting on January 18, 1950.

The hostesses are: Mrs. Mason G. Lawson, Mrs. A. Nettleship, Mrs. John Samuel, Mrs. J. K. Donaldson, Mrs. Drew Agar and Mrs. E. S. Chappell. The program is in charge of the Legislation Committee, composed of Mrs. Ben Means and Mrs. Erner Jones. They will present Mr. Eugene Warren, Little Rock attorney, who will speak on "Law and Medicine."

Mrs. Gordon P. Oates,
Publicity Secretary.

Mrs. L. K. Hundley, state president, was honored by the Jefferson County Medical Auxiliary December 2, 1949, in the home of Mrs. Clyde Hart, Jr. Mrs. Howard Stern was co-hostess.

At the appointed hour members were invited into the dining room where a lovely buffet luncheon was served. Mrs. John Walker and Mrs.



Fred Hames presided at the table which was centered with red and white carnations.

After luncheon the president, Mrs. R. D. Dickens, presided over a short business session. Mrs. Howard Stern then introduced Mrs. Hundley, who needed no introduction to the members. Mrs. Hundley's inspiring talk on "Why I Believe in the Woman's Auxiliary Program" was thoroughly enjoyed. Bridge and Canasta were played during the remainder of the afternoon.

Mrs. Ross E. Maynard,
Publicity Chairman.

The Union County Woman's Auxiliary met Wednesday, December 7th in the Ming room of the Garrett Hotel for luncheon. Eleven members and two guests were present. The table was lovely with a miniature Christmas tree used as a centerpiece.

The Auxiliary was honored to have as guest speaker, Mrs. Louis K. Hundley of Pine Bluff, president of the Arkansas Medical Auxiliary. Mrs. Hundley gave a very interesting talk on Socialized Medicine. Mrs. J. R. Phelps of Pine Bluff was also a guest.

Mrs. George Burton,
Publicity Chairman.

The Garland County Medical Auxiliary met at the home of Mrs. Robert Atkinson, with Mrs. H. King Wade, Jr., Mrs. L. Bohnen and Mrs. N. B. Bunch as co-hostesses. The twenty-five members present brought Christmas boxes for underprivileged children.

The president, Mrs. Leeman King, presided over a short business meeting. Plans for the Cancer Program will be discussed at the January meeting. The group voted to spend \$75 for sheets for the Old Folks Home.

Mrs. Geo. Fletcher gave some lovely poems from her "Scrips and Scraps," "Leisure" and "A Xmas Pledge."

Mrs. Fred Pathman gave the beautiful Xmas story "The Man Who Owned the Stable"—by Arnold Currie.

Mrs. Frank Adams led the group in singing Xmas carols.

Delicious refreshments were served from a beautiful Christmas table. Mrs. W. K. Smith served with Mrs. Paul Wood assisting.

The January meeting will be with Mrs. Charles Lutterloh.

BOOK REVIEW

A Textbook of Neuropathology—With Clinical, Anatomical and Technical Supplements: By Ben W. Lichtenstein, B. S., M. S., M. D., Associate Professor of Neurology, the University of Illinois College of Medicine; State Neuropathologist, Illinois Neuropsychiatric Institute. New, 1st Edition. 474 pages with 282 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$9.50.

This textbook is directed not only to students of neuropathology and pathologists, but to those interested in clinical neurology as well. Sections are devoted to the basic changes in neurological diseases as well as specific descriptions of the degenerative, inflammatory, and neoplastic disorders. The vascular disorders are covered in a comprehensive fashion, as well as the various malformations of the brain.

Of additional interest to the pathologist are the sections on post-mortem technique and special stains.

The concept used for description of specific diseases of the central nervous system is to correlate the anatomical location for the disease with the function of the part. Both gross and microscopic descriptions are extensive, and there is a large number of excellent illustrations. Recent concepts of etiology of many of the neurological diseases are included with well rounded bibliographies at the end of each chapter.

The student will be particularly interested in the clinical supplement, a section on syndromes, paralyses, and uncommon diseases.

The text is very comprehensive and covers not only the common, but also the more unusual and rare lesions. This is a very excellent textbook, and is recommended to anyone interested in clinical neurology, neuropathology, or neurophysiology.

Medical Etymology—The History and Derivation of Medical Terms for Students of Medicine, Dentistry and Nursing. By O. H. Perry Pepper, M.D., Professor of Medicine, University of Pennsylvania. 263 pages. Philadelphia and London: W. B. Saunders Company, 1949. Price \$5.50.

Dr. Pepper has compiled a most interesting book telling the "how and why" of the meaning of medical terms and words. The root and original meaning of each word, the changes which have occurred in its meaning and often the historical and biographical sidelights, add to the pleasure of reading this book.

The American Nurses Dictionary—The Definition and Pronunciation of Terms in the Nursing Vocabulary: By Alice L. Price, B.S., R.N., Instructor in Nursing Arts at Columbia Hospital, Milwaukee. 656 pages. Philadelphia and London: W. B. Saunders Company, 1949. Price \$3.75.

This is planned as a dictionary for nurses and defines approximately 25,000 words. It is the first book of its kind and while it is of value as an introduction to medical terminology, one of the smaller medical dictionaries would serve equally well.

More Than Armies: The Story of Edward H. Cary, M.D.

By Boothe Mooney. Price \$5.00. Pp. 276. Dallas: Mathis, Van Nort and Company, 1948.

This is the life story of Edward H. Cary, physician, civic leader, medical statesman. To those who know him well and to those who do not, the book will bring both interest and inspiration.

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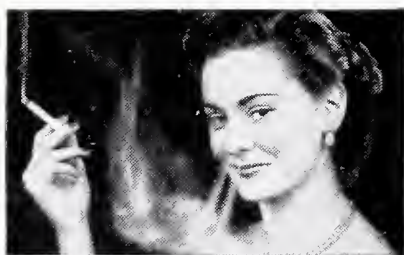


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THE STUDY OF CONVULSIVE FRACTURES OF THE DORSAL SPINE FOLLOWING ELECTRIC SHOCK THERAPY IN PSYCHOTIC PATIENTS *

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Introduction. Although many of us in the practice of medicine are not directly concerned with psychotic patients, the great prevalence of these ailments behooves us to be familiar with them and with therapeutic procedures now being used. Moreover, many of us are called upon to treat these patients after they return home from the psychiatric institutions, and it is necessary for us to know what has been done and the possible complications which may arise.

Convulsive seizures have been employed in the treatment of psychotic patients now for a considerable period of time, but in recent years the tendency has been to utilize electric shock to produce these convulsive seizures to a greater extent. The conception has arisen that electric shock convulsive seizures are more benign in type than seizures due to either insulin shock or metrazol. It is not our purpose at this time to debate the merits of such convulsive seizures but to call attention at this time to some of the complications which may arise in such treatment. Actually, any detrimental aspects which such therapy may have would have to be very considerable before discontinuing such therapy in view of the hopeless state of the patients who are being thus treated.

In very recent years several reports have appeared indicating that there is a very low incidence of fractures of the spine in connection with electric shock therapy. Actually there have been very few good comprehensive studies to indicate with any degree of accuracy the incidence of such fractures and to indicate whether or not there are any predisposing factors which can be

demonstrated, or any definite prophylactic measures which can be undertaken.

Method of Study. In order to evaluate this aspect of the problem more accurately, all patients who received electric shock therapy at the North Little Rock Veterans Administration Hospital between October 13, 1947, and June of 1948 were routinely studied from the standpoint of convulsive fractures of the dorsal spine. This series has already been reported in considerable detail elsewhere, but it is our purpose at this time to review the findings for you very briefly. Although there were 213 such patients scheduled for this treatment during this time interval, one of these patients was inadvertently omitted from the series making our series 212 patients instead. The Neuropsychiatric Department administered the shock treatment in their routine fashion. In some instances curare was administered in quantities of 1 to 4 cc of Squibb's "Intocostin." The latter drug contained approximately 20 mgm of curare per cc.

All patients routinely had a postero-anterior micro-film of the chest, skull films, and lateral films of the dorsal spine prior to the institution of the electric shock treatment. Lateral films of the dorsal spine were thereafter obtained sequentially after the first, second, third, fourth, fifth, tenth, fifteenth, and twentieth shock treatment with a few exceptions to be indicated below. Approximately 150 patients were studied completely in this fashion. Our findings from a radiographic standpoint on the control films as compared with the post-shock films were studied in considerable detail, and an effort was made to correlate the incidence of fracture with any leading factors on the control films prior to shock therapy. A brief attempt was made to evaluate the immediate efficacy of the electric shock therapy on the basis of the clinical response obtained. No effort, however, has been made to make any statements regarding the long term effects of such electric shock therapy.

Age. The factor of age was considered in this group consisting of patients varying in age from late in their teens to somewhat over 60

* Presented before Arkansas Medical Society, Little Rock, Arkansas, April 14, 1949.

years of age. In the overall group of cases there was an incidence of 35.4 per cent of fractures of the dorsal spine. In the various age groups, the only age group with a high incidence of fracture far beyond those of the other age groups was that between 30 and 39 years of age. This age group suffered an incidence of 46 per cent fractures in contrast to the other age groups exclusive of this one with an incidence of fracture of 31 per cent. There were 61 cases in this age group making it a very representative body.

Relationship of Previously Narrowed Vertebrae to Incidence of Shock Fracture. It was found that if there was any anterior narrowness of a vertebral body to be detected on a control film, that this patient had a definite predisposition toward post-shock fractures. However, the vertebra to be fractured was not usually the one that was anteriorly narrowed on the control film.

Thus, there was a total of 80 patients with anteriorly narrowed vertebrae in the dorsal spine prior to the present shock series omitting cases of diagnosable remote or recent osteochondrosis. There were 139 vertebrae thus narrowed in these patients, and although we cannot in every instance say that anterior vertebral wedging indicates a previous compression fracture, nevertheless, the incidence of narrowness of a vertebral body was found to be of significance with regard to the incidence of post-shock fractures.

Of the patients who had anteriorly narrowed vertebrae on the control films, 47.5 per cent developed post-shock fractures. In spite of this predisposition, in only 11 cases were these previously narrowed vertebrae themselves the site of further fracture.

It was also found that amongst those patients with anterior narrowness visible on the control films, that those patients who had a history of previous shock therapy elsewhere or injury to the dorsal spine seemed somewhat less likely to develop convulsive electric shock fractures following the present series of treatments than those who did not have such previous treatment.

Moreover, in those patients who had had previous electric shock or previous injury to the dorsal spine who had no demonstrable anterior narrowness on the control films—these patients were found to be considerably less predisposed to electric shock fracture than the others. The incidence of fracture in this small group was only 17.6 per cent. It would seem then that these patients are in a favored group for not developing electric shock spine fractures from subsequent electric shock therapy.

In summary, however, it may be stated that

anterior narrowness visible in a vertebral body on a control film is perhaps the most important predisposing factor which we have been able to demonstrate pointing toward a high incidence of post-electric shock fractures of the dorsal spine. It is significant, however, that the narrowed vertebral body itself is not usually involved by fracture.

In this group of patients, however, the ones who have had previous electric shock or previous injury to the dorsal spine are perhaps somewhat less likely to develop shock fractures than those who have not such a history.

Sex and Race. Since all the patients were males in the above series, no definite fixed correlations can be drawn, but the incidence in the negro race was similar to that in the white race and hence racial characteristics cannot be considered to be predisposing factors.

The Relationship of Osteochondrosis to the Incidence of Spine Fracture. There was an incidence of only 11.8 per cent of dorsal spine fractures in those patients with demonstrable osteochondrosis on their control films. The incidence of fracture in the remaining group was 39.9 per cent. It can, therefore, be stated that osteochondrosis does not predispose to electric shock fracture of the dorsal spine, despite the marked deformity of the dorsal spine; and in fact, it may be stated that osteochondrosis may permit a notable resistance to the occurrence of post-electric shock spine fractures.

The Distribution of Anteriorly Narrowed Vertebrae as Related to the Distribution of Fractured Dorsal Vertebrae. The third, fourth, and fifth dorsal vertebral bodies accounted for approximately two-thirds of all the vertebral bodies fractured in this series, and when one considers the sixth vertebral body as well, approximately 85 per cent of the fractured vertebrae can be accounted for. Fractures also occurred in other vertebral bodies to a somewhat lesser extent. This, of course, omits all cases of osteochondrosis in view of the fact that these cases fall into a separate category.

Interestingly enough, despite this high correlation of dorsal spine fractures with the incidence of anteriorly narrowed vertebrae on the control film, in only 11 instances were the previously narrowed vertebrae considered to be the site of further fracture.

Efficacy of Curare. Those patients who received curare prior to an electric shock convulsive seizure may be divided into two groups: (1) That group in which curare was given prior to all the electric shock seizures starting from the

very first seizure of the series; (2) those patients who were given curare prior to their convulsive seizures after dorsal spine injury was already noted on the X-ray study of the dorsal spine.

The patients were placed in group I of these two categories by the neuropsychiatrist on the basis of their concept of the patients possible predisposition to convulsive seizure fracture.

Thus there were 98 cases to whom curare was administered with one curare death. Amongst those 98 cases 42 per cent had curare administered from the very start (group I), and 58 per cent had curare after the course of shock treatment began (group II).

It will be recalled that there was an over-all incidence of shock fractures in approximately 35.4 per cent of all of the patients. When curare was administered from the very start, the incidence of fracture in this group of 42 patients was 19.5 per cent—a significant difference. Actually when considering all those patients in whom curare was not administered, the total incidence of fracture was 39.2 per cent.

However, in group II, that is in those cases where curare was administered after the course of electric shock series had already begun, the incidence of fractures was 46.6 per cent. In many of these cases the old fractures progressed and new fractures appeared in addition to the old fractures.

Thus it may be stated that **if curare is to do any good, it must be administered from the very start in this electric shock series.** It is probable that curare can do a great deal of good if one determines beforehand the proper dosage to be administered in each patient.

Relationship of Other Miscellaneous Factors to the Incidence of Fractures of the Dorsal Spine in these Patients. It was found that amongst the various physicians who had administered the shock, the incidence of fracture was approximately the same. It was also found that kyphosis, scoliosis, and deforming spondylosis had no definite bearing upon the incidence of post-electric shock dorsal spine fractures.

When Fracture Discovered. It was found that fractures following electric shock occurred within the first three shock treatments in approximately two-thirds of the cases (63 per cent). And in 78 per cent of the cases within the first five treatments. Less than 5 per cent of the fractures appeared following the fifteenth shock treatment.

It must be apparent, therefore, that any preventive measures must be instituted from the very start of electric shock treatments. Such measures cannot be introduced effectively after

the shock series has begun.

How Fractures First Made Their Appearance and Developed. In studying sequentially and statistically the development of these dorsal spine fractures on the various complete series films, it was found that probably the first manifestation of injury to the vertebral body was an **end-plate impression** (figure one). Following this end-plate impression usually the next step is an **anterior compression** of the dorsal vertebral body to a variable extent. As time went on, the subsequent development was usually a sclerosis of the superior end-plate and possibly some degree of posterior compression as well.

As previously indicated the usual vertebral bodies involved were those vertebral bodies in the region of the maximum curvature of the dorsal spine—namely, T-3, 4, and 5 levels.

It would appear then that the first effect of the convulsive seizure is a hammer-blow onto the superior end-plate of the vertebral body delivered by the entire cervical spine and upper two dorsal segments. This can readily be explained by the marked tetanic contraction which occurs in all of the long muscles of the back following the initial shock. Following this initial shock the small flexor muscles of the spine begin their tetanic contraction superimposing the anterior compression element upon the previous superior end-plate impression. The sclerosis which ultimately becomes manifest is merely a manifestation of healing which is occurring in the injured vertebral body.

It is, however, significant that there is no great relationship of pain to fracture. Very few of the patients spontaneously complained of pain, but of course, this is very difficult to evaluate in a group of mentally incompetent patients. Moreover, it was found that the fracture was just as frequently present as not present in those patients who did complain of pain in the back. Of course, it should be emphasized that no attempt was made to elicit a history of pain or complaint referable to the back. If this were done, perhaps the findings would be different.

Efficacy of Shock Fracture with Regard to Immediate Clinical Improvement. It is interesting to include in this series the notations regarding the clinical improvement in these cases. No attempt has been made to evaluate this factor beyond the initial phase following the courses of shock treatment (approximately 6 months). If one considers a **good result** as that in which a patient improves sufficiently to be discharged with maximum hospital benefits; a moderately

improved patient one who has showed enough improvement to be given trial visits at home in the custody of some responsible person; or also to include in this category those who improved enough to be given privileges on open wards; and those classified as **slight improvement** where the improvement was not sufficient to permit with maximum hospital benefits; a **moderately** them to leave the ward but they did not constitute the behavior problem they did prior to the administration of electric shock therapy—then it is found that a total of 61 per cent of the patients showed some form of clinical improvement following electric shock therapy. However, of this 61 per cent only 35 per cent were listed as good or moderate. Of course, it is difficult to evaluate from our present findings what the ultimate results with regard to these patients will be. Our psychiatrist friends approach this entire phase of the project with a great deal of caution and feel that any evaluation under a period of years would be hazardous and probably fallacious.

Summary. All of us at one time or another are either directly or indirectly concerned with convulsive shock therapy in psychotic patients.

We may state that convulsive fractures of the dorsal spine are not entirely without complication but that these complications are minimal probably in comparison with the type of disease that is being treated.

Following electric shock therapy there is an incidence of 35 per cent of dorsal spine fractures in male patients. This agrees closely with other large series of metrazol convulsive fractures and hence probably there is a closely related mechanism which operates in both types of convulsive seizures. This high incidence is contrary to other small reported series of cases. It is significant that the vertebral body injuries occurred in the first three treatments in almost two-thirds of the cases and within the first five treatments in four-fifths of the cases indicating that any preventive measures which may be used must be instituted from the very start in this mode of therapy.

The third, fourth, and fifth dorsal vertebrae were predominantly affected, slightly higher perhaps in situation than the metrazol fractures of the spine. It would appear that probably the earliest manifestation of fracture in the vertebral body is due to a hammer-blow delivered by the cervical spine and upper two dorsal segments onto the superior end-plates of T-3, 4, and 5 vertebral bodies, in view of the fact that it is this situation where the change of curvature

is most marked. The first manifestation of fracture is, therefore, a superior end-plate impression and this is followed by an anterior compression superimposed.

The sclerosis which later becomes manifest in these vertebral bodies is probably a manifestation of healing.

There are other occasional complications which occur with great infrequency. We have noted bilateral hip fractures in one patient and unilateral hip fracture in another. It is possible that other fractures might also occur depending upon the degree of restraint employed during the treatments.

The only significant predisposing factors which we have been able to demonstrate in the above series of cases are as follows: Age group 30 to 39 seem to be particularly predisposed; and anterior narrowness of a vertebral body visible on the control film would seem to indicate that there is some inherent defect within the dorsal spine proper which predisposes to post-shock fracture. Osteochondrosis, however, appeared to project a degree of resistance to the dorsal spine.

It is significant to note that curare, in order to be effective, must be administered from the very start of the course of the treatment. If administered once the fracture has already appeared, it does not alleviate the condition whatsoever nor does it prevent the further appearance of more fractures. It is probable also that curare when properly administered in proper dosage is the most efficacious agent known to date in the prevention of these fractures. And if every precaution be taken with antidote for intravenous injection immediately at hand, it is probable that curare can be used with comparative safety.

No attempt has been made in the above series to evaluate any long term results from the standpoint of the clinical response of the patients to whom shock was administered. It is perhaps significant, however, that in the immediate results (within 6 months) one-third of the patients improved sufficiently to be classified as good or moderate improvement; one-third improved very slightly; and in the remaining one-third improvement was not present or was too temporary to be considered of any value.

Other factors such as race, deforming spondylosis, kyphosis, Schmorl's nodes, the physician who administered the shock, and the patient's weight appeared not to be correlated with post-electric shock convulsive fractures whatsoever.

GASTROINTESTINAL MANIFESTATIONS OF MYOCARDIAL INFARCTION *

By FRANK M. ADAMS, M. D.
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Prior to 1912, when James B. Herrick¹ accurately described the clinical syndrome of coronary thrombosis, this illness was often cloaked under the guise of acute indigestion, ptomaine poisoning, acute dilatation of the heart, acute heart failure, and numerous other presumed disorders. Many leading cardiologists^{2 3 4 5} mention nausea and vomiting as manifestations of acute myocardial infarction. White⁶, on the other hand, makes the statement that "Acute myocardial infarction from coronary thrombosis rarely excites gastrointestinal symptoms. Nausea and vomiting, when they occur, are due more often to the narcotic given for the relief of pain than directly to the disease." Eggleston⁷ states that nausea and vomiting may occur but that it is often difficult to decide whether they are caused by the infarction or an opiate. It has been our experience that myocardial infarction often is accompanied by symptoms of disturbed gastrointestinal function. In fact, gastrointestinal symptoms may be the outstanding, and occasionally, the only complaint following myocardial infarction. This possibility is important to keep in mind in the differential diagnosis of any acute gastrointestinal disorder occurring in middle or late life. Otherwise the likelihood of myocardial infarction may be overlooked with disastrous results.

The patient with severe substernal pain, cyanosis, ashen pallor, drop in blood pressure, drenching sweat, and restlessness presents no great problem as regards the diagnosis of myocardial infarction. When the pain is felt in the epigastrium and is accompanied by symptoms of shock, nausea, vomiting, tenderness and muscular clinical picture. Instances are on record where more complex. Perforation of an abdominal viscus, acute gallbladder disease, acute pancreatitis, or mesenteric thrombosis may present a similar clinical picture. Instances are on record where patients with myocardial infarction have been subjected to laparotomy. Because of the similarity in the autonomic nervous system innervation of the heart and gastrointestinal tract, it is not unusual for heart disease to be accompanied

by certain disturbances in gastrointestinal function. The nausea and vomiting associated with myocardial infarction are thought to be due to reduction in stomach tonus and reverse gastric peristalsis due to a viscerovisceral reflex.⁸

Certain patients that we have seen with myocardial infarction have had the true nature of their illness so disguised by gastrointestinal symptoms that a mistaken diagnosis might well have been made. An awareness of the possibility of myocardial infarction in similar instances should aid in the detection of this serious malady.

Case 1: A 66-year-old white male ate a large amount of chili for lunch. Thirty minutes later he became nauseated and vomited. At the same time he developed a constant severe pain in the epigastrium and left upper quadrant. There was no chest or arm pain and no dyspnea. Because the abdominal pain, nausea and vomiting continued, the patient was seen by his home physician and was admitted to a hospital the following day. On admission the patient appeared acutely ill and complained of severe epigastric pain. His temperature was 99.4 degrees F. and the pulse 100. The blood pressure was 130/90. Physical examination was negative except for tenderness and rigidity in the epigastrium and left upper quadrant. The white blood cell count was 18,050 with a normal differential count. Urinalysis was negative except for a few red blood cells which were thought due to a recent catheterization. A flat film of the abdomen showed no X-ray evidence of intestinal obstruction or perforated viscus. The surgeon in charge of the patient was considering the possibility of doing an exploratory laparotomy, and a medical consultation was requested for preoperative evaluation of the general condition of the patient. An electrocardiogram showed the characteristic ST-T changes of a recent anterior wall myocardial infarction. Serial electrocardiograms confirmed the diagnosis. The anticipated surgery was abandoned. With bed rest and symptomatic treatment the patient made an uneventful recovery.

Case 2: A 70-year-old white male was attending the funeral of his wife. He became nauseated and vomited. He, as well as other members of his family, attributed the stomach symptoms to the emotional upset incident to the funeral. The following night the patient became so short of breath that he had to sit on the edge of the bed to breathe. There was no chest pain. The following morning he was admitted to the hospital. Examination revealed an elderly male who was

* From the Department of Medicine, Wade Clinic, Hot Springs National Park, Arkansas.

having considerable respiratory difficulty. The temperature was 97 degrees F., and the pulse rate 104. The blood pressure was 120/70. Examination of the lungs revealed moist rales at the lung bases with numerous inspiratory and expiratory rhonchi. Due to pulmonary emphysema, it was impossible to outline the borders of the heart. The heart sounds were distant. No murmurs or arrhythmia were present. There was slight muscular rigidity in the epigastrium. Examination of the blood showed a red blood cell count of 3,610,000 with 11 gm. hemoglobin and a white blood cell count of 9,900. Urinalysis showed a large amount of albumin and an occasional pus cell. The blood nonprotein nitrogen was 128 mg. per cent. Chest X-ray revealed cardiac enlargement, with a cardiothoracic ratio of 17:28.7. An electrocardiogram showed evidence of recent myocardial infarction of the anterior wall type. The patient expired suddenly two days later.

Case 3: A 53-year-old white male developed epigastric discomfort upon returning home from a baseball game. The symptoms were attributed to some peanuts that he had eaten at the game. During the night he vomited once and passed four loose bowel movements. When seen the following morning the patient appeared pale and weak. Physical examination was essentially negative except for moderate tenderness over the entire abdomen. Because further questioning revealed that there had been some sensation of fullness in the lower sternal region, an electrocardiogram was made at the bedside of the patient at noon the same day with the idea of allaying any fears that the patient might have about a possible heart attack. The tracing revealed characteristic changes of early posterior wall infarction. The patient was admitted to an army general hospital where the diagnosis of myocardial infarction was confirmed.

Case 4: A 71-year-old white male ate a seafood plate and later attended the horse races. Three hours after the meal, the patient became nauseated, vomited, and fainted. He was seen by the track physician who sent him to the hospital. On admission the patient was covered with perspiration. He was restless and thrashed about in bed. He immediately called for a bedpan and passed a large formed stool, even though he had already had his usual morning evacuation. The patient complained of severe nausea. He had to be questioned repeatedly before he would admit that he was experiencing

slight substernal "oppression." The blood pressure was 126/80, the pulse 76, and the temperature 99.2 degrees F. Physical examination was essentially negative. The white blood cell count was 16,300. Urinalysis was negative. An electrocardiogram made on admission showed classical findings of posterior wall myocardial infarction. The patient received anti-coagulant therapy (dicumarol) and made an uneventful recovery.

Case 5: A 67-year-old white female developed pain in both arms while she was eating breakfast. The pain persisted and she became nauseated. After lying down, the nausea became more pronounced and she vomited in a nearby container. Previous attacks of nausea and vomiting had occurred at intervals following a cholecystectomy ten years previously, but none of the previous attacks had been accompanied by arm pain. On examination, the patient appeared pale and anxious. The blood pressure was 174/90, the pulse was 60, and the temperature was 98 degrees F. Physical examination was essentially negative. An electrocardiogram was done in the home and showed typical early changes of posterior wall infarction. Serial electrocardiograms done after admission to the hospital confirmed the diagnosis of myocardial infarction.

Discussion

Autopsy studies show that myocardial infarction is more frequent than clinical diagnosis would indicate. Many persons experience myocardial infarction without any symptoms and survive the attack without any medical care.⁹ Other instances of myocardial infarction are manifested in such an atypical manner that the diagnosis is not suspected by either the patient or his physician. Gastrointestinal symptoms may frequently accompany the injury to the myocardium and further confuse the diagnosis. Nausea and vomiting occurred in all five of the cases presented in this paper, and none had had a narcotic before the onset of the nausea and vomiting. In case 1 all the symptoms were suggestive of an acute surgical emergency and an operation was considered before the true nature of the disease was detected. In case 2 the infarction occurred during a period of emotional stress. In this day of psychosomatic approach to disease, it would have been easy to explain his symptoms on a functional basis. The onset of orthopnea gave the clue of a weakened myocardium. In

case 3 the chief complaint was related to a diarrhea which may or may not have been incidental to the onset of myocardial infarction. In case 4 the symptoms were those usually encountered in food poisoning with nausea, vomiting, and fainting being the chief manifestations and the sub-sternal oppression constituting a lesser complaint. The diagnosis was more obvious in case 5 be-cause of the bilateral arm pain, but even in this case the patient was more impressed by the pos-sibility of her symptoms being due to a biliary tract disorder than heart disease.

Conclusions

1. Gastrointestinal symptoms often accom-pany myocardial infarction.
2. In certain instances, gastrointestinal symp-toms may be the sole manifestation of myocar-dial infarction.
3. Nausea and vomiting may occur before any opiate is administered.
4. Case reports are presented to illustrate the confusion that might result in making a diag-nosis in patients with atypical symptoms.
5. The electrocardiogram was of great value in making the correct diagnosis in each instance.

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POSTGRADUATE STUDY

In 1949, the University of Arkansas School of Medicine, in cooperation with the Maternal Wel-fare Committee of the Arkansas Medical Society and the Arkansas State Board of Health, under-took to establish a series of postgraduate courses in Obstetrics and Gynecology. Organizational plans for the current year are completed and postgraduate courses have been scheduled to be-gin in the near future.

Under joint sponsorship of the Medical School, this Society and the State Board of Health, the Department of Obstetrics and Gynecology will offer a two to three-day Postgraduate Program to be held at the Medical School in the spring. The course of study will include ward rounds, clinics, conferences, lectures, and demonstra-tions. The program will be arranged so as to provide ample opportunity for informal question periods. Guest speakers and members of the University faculty will bring an integrated review of this specialty to Arkansas physicians.

Because of the type of teaching contemplated, the class will be limited to fifteen registrants, but the course will be repeated from four to six times a year.

Further announcement of details and dates will appear at a later date. However, those plan-ning to attend the initial course are urged to notify the Department of Obstetrics and Gyne-cology at once to insure a place in this session.

Subjects to be covered:

Medical Complications of Pregnancy	Newborn Problems
Toxemia of Pregnancy	Erythroblastosis
Pyelitis and Pyelonephritis	Functional Uterine Bleeding
Late Pregnancy Bleeding	Sterility
Abortion	Pelvic Mensuration
Forceps and Manikin Demonstration	Management of Dystocia
Leucorrhea	Transfusions in Obstetrics and Gynecology
Cancer of Uterus	Ectopic Pregnancy
Regional Anesthesia in Labor	Demonstrations of Obste-tric and Gynecologic Surgical Cases

FOR SALE

The office and equipment of the late Don W. Dykstra in Little Rock. Equipment includes X-ray, electric cardiograph, diathermy, surgical instruments, two examining rooms and consul-tation and reception room furniture.

FOR SALE

Spencer Binocular Microscope

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TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

EVIDENCE that the practice of X-raying the chests of all patients admitted to general hospitals is an efficient means of discovering unsuspected cases of tuberculosis continues to accumulate. The procedure not only aids the physician and gives the patient the benefit of early diagnosis; it also protects hospital personnel and advances the control of tuberculosis in the community.

ROUTINE CHEST PHOTO-ROENTGENOGRAPHY IN BARONESS ERLANGER HOSPITAL, CHATTANOOGA, TENNESSEE

Early in 1946, Baroness Erlanger Hospital in Chattanooga accepted as a permanent loan from the State Department of Public Health in Tennessee photo-roentgen equipment for the purpose of doing routine chest roentgenograms on all persons admitted to the hospital. At that time, the Chattanooga-Hamilton County Health Department was operating a stationary photo-fluorograph for clinic use and a mobile unit for the roentgenographic examination of persons in industry, schools, and the community. The equipment placed at the general hospital, therefore, rounded out the case-finding program and made routine chest roentgenograms for the discovery of cases of tuberculosis available to another population group.

Procedure

The stationary 35 mm. photo-fluorograph in the health department clinic is used to examine contacts of known cases of tuberculosis, food-handlers, teachers, barbers and beauty operators, persons applying for employment in certain industries, patients referred by physicians, persons desiring roentgenograms because of symptoms or for some other reason, a few students referred from schools, and a miscellaneous group. The individuals included in this survey are designated the Health Department Clinic Group.

The groups surveyed by the mobile unit are classified as community, industrial, or school. The community group includes adults living in residential areas of Chattanooga and Hamilton County. The industrial group consists primarily of workers employed in manufacturing plants. In

the school group are students 15 years of age or over. The three subgroups are combined as the Mobile Unit Group.

The plan to obtain chest roentgenograms routinely on all persons admitted to the Baroness Erlanger Hospital was not attempted at first. Employees and any nonpaying patients (primarily indigent), a few private patients, and persons referred from the emergency room were included in the first survey. This group of persons is designated the Hospital Group.

Analyses of the clinic and mobile unit groups are for the year 1946, and that for the hospital group is for the period April 1 through December 31, 1947. This report seems indicated because of the relatively high percentage of pulmonary tuberculosis discovered in the group examined roentgenographically on admission to the hospital.

Results of Photo-roentgen Examinations from Three Types of Surveys, Chattanooga-Hamilton County 1946-1947

Group	Number Examined	Cases	
		Number	Per cent
Health Department Clinic, 1946	13,966	383	2.7
Mobile Unit, 1946.....	14,293	290	2.0
Hospital Unit, 1947.....	5,187	193	3.7
All surveys	33,446	866	2.6

Discussion

The highest percentage of cases of tuberculosis (3.7) was found in the hospital group, but this should not minimize the finding that 2.0 and 2.7 per cent of persons examined in the mobile unit and clinic groups had tuberculosis.* Surveys such as this have proved their value repeatedly during recent years. Routine roentgenographic examination of hospital admissions, however, has not received the attention it merits. The risk to the medical student, nurse, or hospital employee of

*Editor's note: These percentages refer to reinfection type tuberculosis, but it should be noted that this does not mean that all cases were clinically significant.

cases of unrecognized tuberculosis in the hospital population has been noted, but all too often the exceptional opportunity for tuberculosis case finding provided by the hospital population has been overlooked. Unrecognized tuberculosis among hospital employees and patients imposes a responsibility upon the hospital that is difficult to ignore.

It is interesting to compare the make-up of the hospital survey group and the health department clinic group. In no subgroup of the mobile unit group has tuberculosis been found to be higher than 2.7 per cent. There is no outpatient tuberculosis clinic at Baroness Erlanger Hospital, and patients are admitted for hospital and clinic services for complaints other than tuberculosis. Except for diabetes, tumor, and venereal disease clinics (which might be expected to have considerable unrecognized tuberculosis), there was no special subgroup that contributed to the high percentage (3.7) of persons found with tuberculosis in the hospital population. On the other hand, the health department clinic examined such subgroups as contacts (5.5 per cent with tuberculosis), barbers and beauty operators (7.7 per cent), and patients referred by physicians (9.3 per cent), in all of whom cases of tuberculosis are discovered frequently. This makes it more apparent that routine chest roentgenographic examinations of patients admitted to general hospitals should be seriously considered as a responsibility of the hospital and its contribution to the tuberculosis control program.

The success of any tuberculosis case-finding program depends upon the finding of early cases of the disease. In the clinic and mobile unit groups 65 to 70 per cent of the lesions discovered were minimal in extent. It was surprising to find that among the hospital population examined, 92 per cent of the lesions discovered were classified as minimal. In only 7 per cent of the patients were the lesions moderately advanced, and in only one per cent were the lesions far advanced. Of the total number of cases of tuberculosis discovered, 21 per cent were active lesions of minimal extent. The amount of tuberculosis found among young adults was high in the hospital group.

With the advent of photo-fluorography it was expected that many general hospitals would take advantage of this economical technique and adopt chest roentgenograms as a routine proce-

dure. This has not occurred. While mass radiographic procedures are taken for granted in other population groups, there still seems to be some reluctance to use routine chest roentgenography on general hospital patients. This reluctance is difficult to understand. It appears that this one population group has been handed to those seeking out unsuspected cases of tuberculosis in the community "on a silver platter."

Routine Chest Photo-roentgenography in Baroness Erlanger Hospital, Chattanooga, Tennessee, Paul M. Golley, M. D., *The American Review of Tuberculosis*, September, 1949.

OSCAR A. JAMISON, age 76, Tuckerman, died January 27th following a heart attack. Born in Green county, Indiana, he graduated from Barnes Medical College, Saint Louis, in 1901. He was a member of the board of stewards of the Methodist church, member of the Masonic bodies, a member of the Town Council, a director in the Bank of Tuckerman, and a charter member and past commander of the Newport post of the American Legion. During World War I he served in the army medical corps. Survivors are his wife, a son and a daughter.

WALTER W. BROWN, age 53 years, Hardy, died December 13, 1948. A graduate of the Kansas City College of Medicine and Surgery in 1922, he had practiced in Hardy for several years. He was a member of the Lawrence County Medical Society. Surviving relatives are two brothers.

THERON E. FULLER, age 65 years, Texarkana, died February 1st following a heart attack. Born in New Boston, Texas, he graduated from Vanderbilt University School of Medicine and had practiced in Texarkana since 1908 and had been associated with A. W. Roberts since 1929. He was chairman of the board of stewards of the Methodist church, a charter member of the Rotary club, a director of the Texarkana Hospital and of the Texarkana National Bank and a member of specialty societies. Surviving relatives are his wife and a son.

THE JOURNAL

OF THE
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under direction of the Council

W. R. BROOKSHER, M. D., Editor
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EDITORIAL

A ONE-SENTENCE EDITORIAL

It seems the time to pay some attention to what is being done to us as well as for us.

A ONE-SENTENCE EDITORIAL

It is the obligation of the physician to present his patient with the facts and the necessity of voluntary medical insurance as a means of insuring against burdensome medical costs well within the reach of self-supporting people.

OUR OWN DEPARTMENT OF UNDERSTATEMENTS

"This Committee has a right to be proud of the fact that the Social Security Act has been successful in accomplishing one primary objective—the abolition of the old-fashioned poor house"—Arthur J. Altmeyer, testifying before the Senate Committee on Finance, January 17, 1950.

POSTGRADUATE COURSE IN OBSTETRICS AND GYNECOLOGY

A new departure in the field of postgraduate education in Arkansas is the first three-day course to be held at the University of Arkansas School of Medicine March 27th, 28th and 29th, jointly sponsored by the Arkansas Medical Society, the University of Arkansas School of Medicine and the Arkansas State Board of Health. Included will be clinics, conferences, ward rounds, lectures and demonstration by members of the medical school faculty and guest speakers. The class will be limited to 15 registrants because of the type of teaching but the course will be repeated four to six times during the year. Members may obtain full information from the Department of Obstetrics and Gynecology, University of Arkansas School of Medicine, Little Rock.

THE ANNUAL SESSION

This issue of The Journal contains the preliminary program and announcements of the 74th Annual Session of the Society to be held at the Goldman Hotel, Fort Smith, April 17th, 18th and 19th. A scientific program of general interest will be presented and a large scientific exhibit is promised. Limitations of space will restrict the commercial exhibit. Social functions are planned by the host society, the Sebastian County Medical Society, for Monday and Tuesday evenings. The Auxiliary will meet at the Ward Hotel. Early reservations are urged of those members who plan to attend.

In accordance with the instructions of the House of Delegates, reports of various committees likewise appear in this issue. These reports will not be read at the session but may be corrected or amplified by the committees. Members of the House of Delegates are reminded to bring this issue of The Journal to the meeting since handbooks will not be published.

COMMITTEE CHAIRMEN

PETER A. DEISCH, M. D.
Helena

These are the days when those sentimental and conscientious souls, otherwise known as Committee Chairmen, are giving full vent to their enthusiasms. For the efficient ones there generally results a full quota of success and a good annual meeting of the Society.

The qualifications required for a good Committee Chairman are decidedly catholic. He is a

social sort of personage—the friendly type of man, who derives keen pleasure from such an arduous job as acquiring and preparing the scientific exhibits, or the commercial exhibits, or preparing the exacting information contained in the past year's progress of his activity.

He is a person completely immune to discouragement.

A good Committee Chairman is a skillful organizer, a careful and painstaking planner. When an annual meeting once gets under way it moves with relentless speed through its short time span. It is a tumultuously active period with a multitude of distractions. The unhappy Committee Chairman who has failed to plan carefully (though I think all of them do) is very apt to see his happy and carefree confreres doing everything else save what he had hoped they would do.

Probably they are entitled to our encouragement and appreciation.

EDITORIAL COMMENT

RESOLUTIONS AT THE ANNUAL SESSION

The House of Delegates at its 1949 Annual Session acted favorably upon a recommendation of its Reference Committee that the Secretary "shall publish in The Journal an outline for the presentation of any resolutions desired by the membership so that those resolutions may come through proper channels."

The Constitution and By-Laws of the Society make no provision with regard to the introduction of resolutions. The generally accepted practice for such introduction is, of course, through members of the House of Delegates, who can introduce such resolutions or motions during the meetings of that body. The House of Delegates may then take such action as it deems proper on the matter which has been properly presented by one of its members. A county society, therefore, desiring to present a resolution for action by the Society in annual session, would do so through its elected delegate. Similarly, any member of the House of Delegates has the right and authority to introduce for his county society, or for himself as a member of that body, a resolution or motion. No prescribed form has been made available for such presentation.

RANDOM THOUGHTS OF THE SECRETARY

January 27th. Outstanding-New-Member-of-the-Should-Have-Kept-My-Mouth-Shut-Club: Secretary Acheson.

January 28th. In forbidding weather but with the assurance of the captain that if he did not land at Texarkana he would buy our dinner in New Orleans tonight, we take off for the tumor clinic staff meeting in Texar-

kana, and land the captain does with 400 feet and 6 inches of ceiling * * * the Texarkana group presents an instructive and argumentative discussion with profit to all in attendance * * * finally, typifying the unusual in travel arrangements which must trouble our associates, we board a bus for Shreveport and thence by non-stop Mid-Continent airlines home in eighty minutes.

January 30th. It would seem that somewhere in Arkansas there would be available the surgical skill for repair of a hernia and a knee which necessitates a trip to Johns Hopkins for one of our publicized U. of A. athletes.

January 17th. To Fayetteville today, the streets being free, we enjoy the beauty of ice covering trees and bushes on Mt. Sequoyah, reflecting the dim rays of the sun in the dark and gloomy hue of a typical winter day, a day in which thoughts go to fireplaces and comfortable chairs but withal, a view across the hills and away * * * tarrying for some philosophic interchange with Alfred Hathcock but not successful in gaining the basement concession of the Hathcock building for pinball machines and popcorn which would enable waiting patients to while away the time, and perhaps our profit in merchandising endeavor.

January 22nd. With Hunt, Kolb and Richardson to Little Rock in Siegel's yellow Buick, feeling naught like Bea Siegel's description of herself riding in this vehicle although we agree that there is much to her comment.

January 31st. The Missouri lends positive support to the contentions of high Navy brass that the "battleship is here to stay."

February 1st. Meeting with the radiologists at Chicago's Drake to consider own problems, ever hopeful that colleagues will bring needed support in a cause which is more theirs than they suspect.

February 3rd. Hollywood and Stromboli may glamorize it but to us the descriptive words are short and carry the weight of centuries of knowing experience.

February 6th. Speedily to the big town today where rain prevents full enjoyment of window shopping * * * tonight with a home-towner to the Diamond Horseshoe which is nothing but a show until W. C. Handley plays his own "Saint Louis Blues" on a trumpet and Harry Armstrong sings his own "Sweet Adeline" and these thrill the sophisticated out-of-town crowd * * * in small-town manner to the hotel of our fellow citizen spending the balance of the evening seated in the lobby swapping anecdotes with insurance men on a convention, an evening of abandon in the gilded city.

February 7th. With committeemen in joint session on insurance and medical care finding that doctors are not alone in failing to find the answer and that vexation and perturbation surround business and free enterprise wherever it strives in this land of ours * * * grateful for the opportunity to say a good word for medicine and to present its views even on legislation where perhaps we bring some encouragement to the group * * * in a smooth air flight Washington, Richmond, Knoxville, Nashville and Memphis, having the opportunity to see the lighted Capitol, the Washington Monument, and other Washington structures which arouse a tingle in one who loves his Country.

February 14th. Willis Brown talks to the profit of all on the border-line pelvis, holding the attention of the majority who are non-obstetricians throughout as we have seldom seen, and we record the practical nature of his talk by his statement that comparative anatomists may be interested in the type of the pelvis the patient has but that the obstetrician is interested to know if this baby will safely pass through this pelvis.

February 16th. There should be some publicity over the exhibition of "Stromboli" in Fayetteville today.

PROCEEDINGS OF SOCIETIES

The Five-County Medical Society met in dinner-session at DeQueen on January 26th. Pending national legislation in Congress affecting both physicians and lay citizens was discussed by R. C. Dickinson, Horatio, and Mr. Sid Wrightsman, Jr., Fort Smith. The following 1950 officers were elected. President, R. B. Dickinson, DeQueen; Vice-President, Fred Ferguson, Nashville; Secretary-Treasurer, Charles N. Jones, DeQueen.

Garland County Medical Society met in dinner-session at Hot Springs February 14th, with the following scientific program: "Rheumatic Fever in Children," J. L. Rosenzweig, Hot Springs.

The Arkansas Association of Tumor Clinic Staff Members met at Texarkana January 28th. Panel discussions were held on Cervical Cancer with W. B. Harrell, Texarkana; John W. Jones, Texarkana; E. T. Ellison, Texarkana; Howard Stern, Pine Bluff, and W. R. Brooksher, Fort Smith, as participants; Breast Cancer: James B. Kittrell, Texarkana; Carl A. Rosenbaum, Little Rock; H. M. Carney, Texarkana; H. A. Causey, Pine Bluff; A. D. Cathey, El Dorado, and W. R. Brooksher, Fort Smith, as participants; and on Skin Cancer: Howard Klein, Texarkana; J. A. Norton, El Dorado, Carl A. Rosenbaum, Little Rock; Ellis P. Cope, Little Rock, and Fred Hames, Pine Bluff, as participants. D. W. Goldstein, Fort Smith, was elected chairman and the Association will next meet at Fort Smith during May.

The International and Fourth American Congress on Obstetrics and Gynecology will be held May 16th to 19th, 1950, at Hotel Statler, New York. The program is planned to meet the needs of all groups who are interested in improving maternal health. The general practitioner will find much of interest and help in this Congress from the excellent programs and exhibits. Membership dues in the American Committee include the registration fee, as well as subscription to the quarterly magazine, "Mother," and the amount, ten dollars, should be sent to the American Committee on Maternal Welfare, Inc., 24 West Ohio Street, Chicago 10, Illinois.

Ouachita County Medical Society met in dinner session at Camden February 2nd with the following scientific program: "Recent Advances in Treatment of Diabetic Coma," Drew Agar, Little Rock, and "Pending National Legislation," Dale Alford, Little Rock.

The Garland County Medical Society met in dinner session at Belvedere Club January 10th. M. D. Prickett, Little Rock, addressed the meeting on "Recent Advances in Anesthesia."

Joseph L. Rosenzweig, Secretary.

Lawrence County Medical Society has elected the following officers: President, Ralph Joseph; Vice-President, J. B. Elders; Secretary-Treasurer, C. D. Tibbels, and Delegate, J. C. Land. At a recent meeting C. C. Townsend was presented with the Fifty-Year Club pin.

Arkansas County Medical Society has elected the following officers: President, R. H. Whitehead, Jr.; Secretary, R. H. Whitehead, Sr., and Delegate, S. A. Drennen.

Sevier County Medical Society has elected the following officers: President, R. B. Dickinson; Vice-President, C. N. Jones; Secretary-Treasurer, C. E. Kitchens; Delegate, C. E. Kitchens, and Alternate, C. N. Jones.

Sebastian County Medical Society was addressed February 14th by Willis E. Brown, Little Rock, on "Management of Dystocia in the Borderline Pelvis."

M. B. Hoge, Secretary

The Pulaski County Medical Society was addressed February 6th by Jerome S. Levy, "Indications for the Use of Hydrolysates in Peptic Ulcer," and by Ellery C. Gay on the work of the Council of the Arkansas Medical Society.

E. F. Easley, Secretary

Members have received notice of the pediatric postgraduate course to be held at the University of Arkansas School of Medicine March 16th. Guest speakers are Joseph Stokes, Jr., Professor of Pediatrics, University of Pennsylvania, and George Piness, Associate Professor of Medicine, University of Southern California.

A general faculty meeting was held in the Amphitheatre of the School of Medicine on Friday, January 20, 1950, at 7:30 p. m. A discussion of "The General Practitioner Views Medical Education for General Practice" was opened by Dr. L. H. McDaniel, of Tyronza. Dr. McDaniel is Councilor of the First District of the Arkansas Medical Society. Other speakers were Dr. Joe Verser, of Harrisburg, who is Secretary of the State Board of Medical Examiners; Dr. W. H. Anderson, of Booneville, Mississippi, who is Secretary of the Mississippi Medical Society and Editor of the

PERSONALS AND NEWS ITEMS

Clyde D. Rodgers and Charles P. Wickard have moved into their new offices at 1415 West Seventh Street, Little Rock.

S. C. Fulmer, Little Rock, conducted a quiz program on cardiology before the medical staff of the Veterans Administration Regional Office at Little Rock January 20th.

Ralph E. Crigler has been elected a director of the United Building and Loan Association at Fort Smith.

Friedman Sisco has been elected a director of the First State Bank at Springdale.

Alan G. Cazort and Jerome S. Levy have moved to new offices at 1425 West Seventh Street, Little Rock.

A. H. Maddox has been elected medicin of the Paragould voiture, Forty and Eight.

William J. Rhinehart is now associated with Drs. Darmon A. and Barton A. Rhinehart in the practice of roentgenology at 801 Donaghey Building, Little Rock.

The general faculty meeting of the University of Arkansas School of Medicine was held at Riverdale Country Club January 20th. Following the dinner, addresses were given by L. H. McDaniel, Tyrone; Joe Verser, Harrisburg, and W. H. Anderson, Booneville, Mississippi.

"The Responsibilities of the Doctor as a Citizen" by R. B. Robins, Camden, appeared in the January issue of The Journal of the Indiana State Medical Association.

O. C. Melson, Little Rock, has been appointed director of the 1950 American Heart Association campaign in Arkansas.

"Mississippi Doctor," which is the official organ of the Society; and Dr. Earle Hunt, of Clarksville.

Accounts of their experiences in general practice in small communities glorified the general practitioner and proved most entertaining as well as furnishing interesting and valuable statistics and information. Plans of other states for encouraging graduates in medicine to enter general practice were briefly described.

After the meeting, coffee and doughnuts were served in the library of the School of Medicine.

Kenneth G. Jones has opened an office for the practice of orthopedic and traumatic surgery at 1307 Donaghey Building, Little Rock.

T. T. Ross and A. M. Washburn, Little Rock, have been elected to the Founder's Group, American Board of Preventive Medicine and Public Health.

S. W. Hawkins, Fort Smith, attended the recent regional meeting of the American College of Surgeons in El Paso.

Dr. and Mrs. W. W. Verser, Harrisburg, celebrated their golden wedding anniversary January 14th.

J. W. Morris, McCrory, was honored at a community party February 6th celebrating his fifty years of practice.

R. B. Robins, Camden, addressed the Saint Louis County Medical Society January 31st.

Pearl Waddell, Fort Smith, recently took special work at Tulane University.

"Medical Economics" by R. B. Robins, Camden, appeared in the Congressional Record Appendix for February 2nd.

CORRESPONDENCE

February 8, 1950

Dear Dr. Brooksher:

The following announcement is submitted for inclusion in the Journal of the Arkansas Medical Society if you consider it suitable and desirable.

A placement bureau for the convenience of physicians and registered medical technologists of Arkansas will be maintained at the School of Medicine in connection with the medical technology course. We will be glad to receive inquiries from physicians or hospitals who are looking for technicians, or from technicians who are available for employment. There will be no charge or obligation for this service. The University accepts no responsibility other than transmitting the details of the position to prospective applicants or the names of applicants to prospective employers. Address all inquiries to the "Director, Medical Technology Course, University of Arkansas School of Medicine, 1209 McAlmont Street, Little Rock, Arkansas."

Sincerely yours,

Carroll F. Shukers, M.D.
Professor and Head
Clinical Pathology

REPORTS OF COMMITTEES

(To be presented to the 1950 session of the House of Delegates, Fort Smith, April 17, 1950; published in The Journal in accordance with action of the House of Delegates at its 1948 annual session. These reports will not be read at the annual session but committee chairmen may amend or add to the printed reports.)

REPORT OF SCIENTIFIC PROGRAM COMMITTEE

H. KING WADE, JR., Chairman

At the suggestion of Doctor Euclid Smith, President of the Arkansas Medical Society, and with the wholehearted approval of the entire Committee, an attempt was made to arrange a program which would be of the greatest value and the most practical use for the general practitioner in the State of Arkansas.

I would like to extend my sincere thanks at this time to all the members of this Committee for their hard work on behalf of this program, and for their one hundred per cent attendance at each monthly meeting of the Committee. Their co-operation was one hundred per cent, and it was a real pleasure to work with this group.

I also wish to thank Doctor Charles R. Henry for taking the responsibility for, and successfully arranging, the GYN-OB Symposium. I wish to thank Doctor Driver Rowland, of Hot Springs, and the members of the Arkansas Cardiac Society for their co-operation in the preparation of the Cardio-Vascular Symposium.

I wish to thank all the members of the State Society who were interested enough to submit papers. I deeply regret that we were unable to accept every application.

As a Committee, we have one recommendation to make for future programs; we suggest and recommend that the House of Delegates appropriate a given fund and that this fund be turned over to the Chairman of the Program Committee each year for use in obtaining out-of-state speakers.

SCIENTIFIC EXHIBITS COMMITTEE

ANDERSON NETTLESHIP, Chairman

All members of the Committee have been contacted by telephone and letter. These are: Albert S. J. Clarke, Fort Smith; Raymond Cook, Little Rock; E. L. Dunaway, Conway; and Chas. W. Reid, Pine Bluff.

Dr. Clarke is chairman of the local committee on scientific exhibits. The annual meeting is to be held in the Goldman Hotel, Fort Smith; and it has been determined that the scientific exhibits will be on the mezzanine floor. The mezzanine floor will accommodate seven booths approximately 12x8 sq. ft. and three smaller booths, so that a total of ten spaces will be available.

Letters have been sent to people who exhibited in last year's scientific exhibition, as well as other doctors and groups throughout the state. Since last year's scientific exhibits were so successful, it is hoped that the exhibits this year will be equally worthwhile. The Committee has made sincere efforts to contact anyone who may wish to contribute to the exhibition, and it is to be hoped that all parties will consider this as a further invitation to give a scientific exhibit.

PRESS COMMITTEE

L. A. WHITTAKER, Chairman

As Chairman of the Press Committee for the Annual Session of this Society to be held in Fort Smith in April, I have contacted Mr. C. F. Byrns, editor of the two Fort Smith

newspapers. Mr. Byrns has assured the Society full co-operation of both papers on press coverage during the Session.

LEGAL AFFAIRS COMMITTEE

J. B. JAMESON, Chairman

Your Committee wishes to make its first annual report. After considerable study and thought we have reached certain conclusions as to the function, policies and recommendations herein submitted.

First, this Committee is to act as a liaison and recommending group between the Arkansas Medical Society and the Arkansas State Board of Medical Examiners and, secondly, to act as the agency of the Arkansas Medical Society in medico-legal affairs.

(1) We find that the Arkansas Medical Society has available, competent legal talent capable of handling any question of a legal nature which might arise. In this we concur and recommend that this or a similar service should continue to be available.

(2) We find that the affairs of the Arkansas State Board of Medical Examiners have been conducted in a commendable way. Their financial condition is good and they are operating within their income, but with a margin not excessive of their needs. A detailed financial report will be made through the proper channels at a future date. They have excellent legal talent capable of handling any situation which might arise. They also have at their command means of prompt and efficient investigations of any infraction of the medical practice act. We wish to commend them for their untiring efforts and in the work they are doing. We therefore wish to recommend to the Arkansas Medical Society, its official bodies and individual members, that:

(1) In the future when anything arises which pertains to the existing policy of the State Board of Examiners, conduct of affairs, or expenditures, it first be submitted to this Committee through its chairman at that time, for proper investigation and recommendations. By expenditures we mean the transfer of funds to other agencies, and not funds used by them in the conduct of their business. It being understood that such recommendations made by this Committee will be referred to House of Delegates for approval or disapproval.

(2) That any known violation of the Medical Practice Act, first be reported to the chairman of this Committee, in writing, with as much evidence as possible. It is to be desired, if possible, that such notice or request for investigation come from the county society involved or from the nearest society, if the county involved is not organized.

(3) We recommend that at present no change be made in the annual registration fee.

(4) We recommend that in the near future the state society, through its Legislative Committee, cooperating with the State Board of Examiners, begin to think about either rewriting or bringing up to date the existing Medical Practice Act.

We also recommend that the State Board of Examiners in a like manner use the offices of the Legal Affairs Committee in any way they see fit, to bring before the State Society, any question requiring official action.

It is our hope that in adopting these recommendations a closer and more harmonious situation can be effected between the State Society and the Board of Examiners.

MEDICAL SERVICE COMMITTEE

J. A. HENRY, Chairman

The following is a report of the Medical Service Com-

mittee of which Dr. J. A. Henry, Russellville, is chairman; composed of the following men: Dr. Norman Peacock, Ashdown; Dr. J. F. Jackson, Newport; Dr. Dickins, Pine Bluff; and Dr. John Sneed, Conway (not participating).

The report of the Committee's work, and the recommendations resulting from this work, are as follows:

Recommendation 1. We recommend that the State Medical Society endorse, and initiate legislation, setting up a medical scholarship loan program for the State of Arkansas.

The purpose of this scholarship program is to fulfill the need of family physicians in the rural areas of Arkansas. Approximately seventy-five per cent of the physicians practicing in the rural areas are now sixty years of age or older; and it is our belief that the majority of these physicians will not be replaced, after they pass on. The shortage of physicians in the rural areas threatens the welfare of a large number of the citizens of Arkansas.

Socialized Medicine proposes that doctors will be sent into these rural areas where there is a real need. It behooves the State Medical Society to do what they can to rectify this need of doctors in the rural communities. By doing so, we will be attempting to solve the problem, and to let the public know that we are interested in their needs. We feel that this will be striking a real blow against the threat of Socialized Medicine in the State of Arkansas.

At present there are nine states which have scholarship loan programs; with the idea in view of the students returning to the rural sections and practicing a certain length of time, in order to pay back the loan which enabled them to attend school. Mississippi has the most ambitious and probably, so far, the most successful plan to aid students to obtain a medical education, and to return to rural practice. The proposed plan of ours is modeled partially after the Mississippi plan.

Our recommendations toward setting up such a program are as follows:

A. The source of funds we believe should come through the State Legislature. We feel that a program of this sort would be a great aid to the state, and that it should be financed by the state. We believe that no federal funds should be used in this program, because we fear that the use of federal funds would take the program out of the hands of the state, and the State Medical Society, and that we would be playing into the hands of Socialized Medicine.

B. The maximum total loan, per student, we proposed to be four thousand dollars. The maximum amount of the loan available per year, per student, would be one thousand dollars.

C. The loan will be available to any bona fide resident of the State of Arkansas who has finished his pre-medical requirements, and who can prove that he is unable to finance his medical education without the aid which we propose to offer. We think this student should be a resident of the state for at least eight years in order to be eligible for assistance. We believe that a limited number of the scholarships should be offered to colored students in order that certain rural areas composed chiefly of colored people could have better medical assistance.

D. We think the student should be allowed to attend any approved, class A, Medical School in the United States.

E. After having finished his medical education, we think the student should be required to serve one year rotating internship; with an option to take two years of rotating internship. We do not think he should be permitted to take more than two years of hospital work before fulfilling his obligation to return to rural practice.

F. The method of credit: We think that the student

should be credited one thousand dollars for each year that he spends in rural practice.

G. We think the size of the community should be one of twenty-five hundred population or less, according to the census of 1950.

H. We think that he should be given complete credit for his loan after having finished four years of practice in a rural community. We recommend that he spend a minimum of two years of such practice, regardless of the amount of money which he has received.

I. We think that these students should be selected by a board whose chairman is the President of the State Medical Society, and a group of four or five other doctors, who will serve three to four-year terms. We think there should be no set time for the duration of this program.

J. We feel that a student who receives this aid should be under a moral obligation to serve his time in rural practice. However, we think that to forestall any possibility of the student not doing so that he receive a temporary license to practice in the State of Arkansas. This license would be revoked in the event he failed to fulfill his part of the contract.

K. We feel that after the doctor has spent the minimum of two years in rural practice, and in event that he wants to leave, that he be allowed to do so, after paying his remaining indebtedness plus two per cent interest.

L. We do not feel that any definite limit should be set on the number of students. However, we think that four or five students in each class, that is a total of sixteen to twenty students, would be a fair beginning. A program of this kind would not be too expensive, and we feel that if it were endorsed by the State Medical Society, and with the proper publicity, that it could be put through the State Legislature without too much difficulty.

M. We feel that it would be doing something concrete to aid the rural sections in obtaining good doctors. We think that we would be doing a great service to worthy and needy students who might not be able to go through medical school without such assistance. We also feel that such a program might induce these men, once in rural practice, to form groups, and then to form small hospitals, which would be one of the main answers to the need of a better type of medical practice in the rural sections.

Recommendation 2. We suggest that the University of Arkansas School of Medicine require each senior student to serve a two weeks preceptorship, with a general practitioner. We think that preferably this practitioner should be located in a small community or in a rural area. We think that this would do much to educate the student, and to create interest in general practice.

Recommendation 3. We recommend that the State Medical Society each year sponsor a dinner at one of the hotels in Little Rock, to which would be invited all the residents, and assistant residents, in the approved hospitals in Arkansas.

We suggest that this be a forum at which time these residents could ask questions of a representative group of doctors in rural practice. In this way, the residents could gain a better idea and possible interest in general practice in small communities.

Also that the State Medical Society, at that time, have a list available of the communities which need and desire a doctor.

Recommendation 4. We suggest also that the University of Arkansas School of Medicine, through the University Hospital, endeavor to create a two-year rotating internship which is primarily for men who wish to go into general practice.

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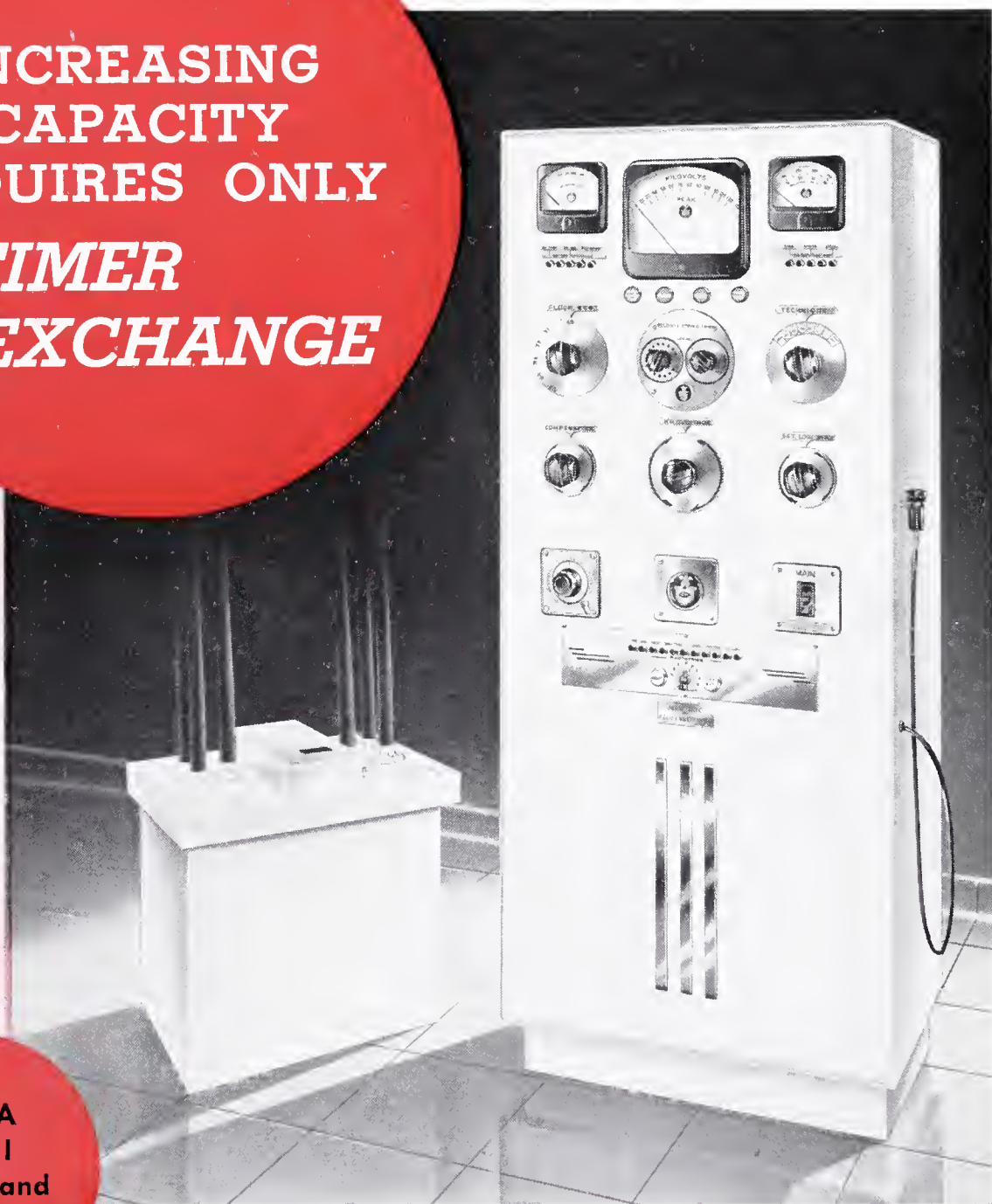
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Recommendation 5. The Committee was directed to meet with and to discuss with Dr. Joe T. Shuffield, the various agencies engaged in helping the crippled of Arkansas.

This was done January 29, 1950, and it was found that no serious difficulties or conflicts existed.

A letter was sent to the heads of the various agencies, advising them of the existence of a Medical Service Committee of the State Medical Society, and of our desire to be of any possible assistance.

MILITARY MEDICINE COMMITTEE

EWING M. NIXON, *Chairman*

The following is submitted as a report of the Military Medicine Committee of the Committee of Medical Service of the Arkansas Medical Society.

In November, the chairman of this sub-committee met with the other chairmen of the medical service section at the Albert Pike Hotel, Little Rock. This meeting was of distinct interest to the writer in that the functions of the Military Medicine Committee and other committees were discussed.

On December 8, 1949, the chairman of this sub-committee appeared in a panel discussion in the Robinson Auditorium, Little Rock, Arkansas, for a discussion of Governor McMath's disaster relief program. Mr. Herman E. Lindsey, Chief of the Arkansas State Police, acted as chairman of the panel discussion, and the following speakers were heard: Mr. Herman E. Lindsey, Chief, Arkansas State Police; Brig. Gen. H. L. McAllister, Commanding General, Arkansas National Guard; Mrs. Elma B. Boone, State Relations Officer, American Red Cross; Capt. Frank McGibbony, Public Relations Officer, Arkansas State Police; Mr. Jack Warren, Superintendent, Davis Hospital, Pine Bluff; Ewing M. Nixon, Chairman, Military Medicine Committee, Arkansas Medical Society.

From this discussion it is evident that considerable progress has been made towards the establishment of a definite program to combat disasters in the State of Arkansas, and it is paramount that complete cooperation be present in such a disaster. The function of each agency of the Arkansas State Police, the American Red Cross, the Arkansas National Guard, Arkansas State Highway Department, the Arkansas State Board of Health, and the Arkansas Medical Society were carefully discussed. The fullest cooperation from the Society, the County Society, and the individual doctors was assured to the other agencies by the writer.

As an example of the need of further study, planning, and teamwork, the overlapping of aid attempts, and lack of facilities during the tornado at Warren, Arkansas, in January, 1949, was a prominent part of the discussion. It was evident in this discussion that there was considerable duplication of effort, and waste of supplies and personnel during this emergency.

Many of the speakers at the panel discussion complimented the doctors of the State of Arkansas for their willingness to help in the Warren tornado as evidenced by their presence at the site immediately following the disaster. It is hoped that further concerted effort can be had to develop a well-rounded disaster relief program.

VETERANS ADMINISTRATION COMMITTEE

DANIEL H. AUTRY, *Chairman*

Because of reduced budget expenditures and because of increased medical personnel on the staff at the regional office of the Veterans Administration at Little Rock, the total number of fee basis examinations and treatments throughout the state was slightly below the preceding year. Apparently the physicians have become well informed re-

garding the completion of necessary written forms, as the administrative officers of the V.A. report a minimum of difficulties in this regard.

There has been a misunderstanding on the part of many veterans when they were instructed to get a complete examination by their local physician to be sent to the V.A. Rating Board, since such veterans usually felt that the V.A. would be responsible for the cost of such examination. This situation has led to embarrassment on the part of both the veteran and the local physician. Representatives of the V.A. have stated that in the future all letters requesting the veteran to secure such examination will include the information that the veteran must pay the physician his usual charges for same.

Many physicians wonder why they do not receive written hospital summary reports on patients whom they have referred to a V.A. or other Government Hospital. Such reports can be sent only upon written authorization of the patient. It is urged, therefore, that all physicians desiring reports of hospital findings, request that the patient, before leaving the hospital, give written authority for the hospital officials to mail such reports back to the referring physician.

INDUSTRIAL HEALTH COMMITTEE

SAMUEL B. THOMPSON, *Chairman*

The Committee on Industrial Health met in the Donaghey Building, Little Rock, Arkansas, at 2:00 P. M., Sunday, January 29, 1950, with Dr. H. K. Wright of Hot Springs, Dr. Ellis Gardner of Russellville, and Chairman in attendance.

The Committee voted to send Dr. L. D. Massey of Osceola a letter of sympathy, in regard to the recent accident which prevented his attending this meeting.

The standard form for the initial surgeon's report of compensable injuries was examined, with regard to Items 9, 10 and 11. It is the recommendation of this Committee that if the physician in charge should feel that a patient's confidence might be violated in answering these questions, that he should secure an authorization from the patient, before submitting such information.

It is felt that the individual physician should use his own judgment about the running of accessory tests or procedures in determining the patient's general health, following an accident, and seek authorization from the insurance company only where unusual procedures are involved.

The Committee takes cognizance of the fact that there is a statute in the State of Arkansas requiring the reporting of occupational diseases. This has not been very rigidly enforced and it is recommended, to the Society, that the profession cooperate in reporting these diseases.

The Committee recommends that industrial plants operating a health program, including nursing, first aid, etc., set up such a program under the supervision of a medical director, who should be a licensed M. D., who would be responsible for the action of the nurses and first aid men; would familiarize himself with the job requirements and working conditions of the plant, by periodic visits to the plant; and would act in an advisory capacity to the management on elimination of occupational hazards and the provision of first aid to the employees.

The Committee takes cognizance of the existence of the Grievance Committee, established by one of the county medical societies to further better relations between the insurance adjusters and doctors doing industrial work. The function of this committee should be watched with great interest by the Society, in regard to what this type of program has to offer in the way of improving relations between industry and the medical profession.

The Committee recommends that any long-range plans for setting up rehabilitation centers for industrial casual-

ties, that might be advanced by industry or insurance carriers, be encouraged by the State Medical Society.

MENTAL HYGIENE COMMITTEE

GEORGE W. JACKSON, Chairman

The report of last year emphasized the magnitude of the mental health problem in our state by quoting statistics on the incidence of mental illness, as well as comparative figures on general hospital and mental hospital beds. This report will cover only specific phases of the mental health program: The aged, the mentally deficient, sex crimes and sex offenders, personnel training, and progress report of the State Hospital.

The care and treatment of the aged or geriatric type patient is becoming an ever-increasing problem. The advances that have been made in medicine in recent years have increased the life span of the average person and it can be expected that more and more individuals will show mental manifestations in the form of loss of memory, confusion, and disorientation, making them a greater problem of management within the home and many becoming wards of the state. At the time of this writing there are approximately 1,100 such cases confined in our mental institutions. A high percentage of this group could be adequately cared for in some type of home for the aged.

A survey was completed last year by the Council on Children and Youth to determine the approximate number of mentally deficient individuals of school age within our state. This survey revealed that there are approximately 5,000 children within the state who are unable to profit by attendance in the regular public school system, but who would benefit by special classroom instruction. Approximately 4,500 of those individuals could be adequately trained by special classes within our regular public school system. The remaining 500 would require care and training in an institution for the mentally deficient. The Committee on Mental Hygiene last year recommended that steps be taken to construct a building for those cases requiring institutional care near one of our Teachers' Training Institutions and that special courses of instruction be provided in the college to train teachers in the teaching of the mentally handicapped child not only to supply the needs of the institution, but to supply the state-wide needs in carrying out the training program of the regular public school system.

The public's attention has been focused in recent months on the increase in the number of sex crimes and sexual offenders. This Committee is aware of this problem and is most anxious to render any assistance possible in working out the necessary legislation to protect society against these offenders and also to assist in the proper confinement and rehabilitation where possible of the offender. Representatives of the Mental Hygiene Committee met with the newly organized State Crime Commission, entered into a discussion of the problems involved and offered the assistance of this Committee as well as the State Medical Society, in working out a satisfactory solution of this problem.

The development of an adequate mental hygiene program in our state is dependent upon the training of the necessary personnel to carry out such a program, as well as the providing of the necessary physical plants and facilities for adequate treatment of the mentally ill. The State Hospital is our largest mental hospital within the state and, although badly overcrowded, is attempting to improve the treatment received by the patients admitted, as well as to institute training programs which in time will provide the necessary personnel for the state-wide needs. In order that the Medical Society may be acquainted with the prog-

ress that is being made in the State Hospital, a complete report of the operation of this unit for the year 1949, together with a statement of the proposed improvements and progressive changes to be made during 1950, is incorporated in this report.

IMPROVEMENTS AND PROGRESSIVE CHANGES MADE AT THE ARKANSAS STATE HOSPITAL

DURING YEAR 1949

HOSPITAL OPERATION

1. At the request of the superintendent, a comprehensive and thorough survey of all hospital units was made by the Department of Hospitals of the State Health Department. All discrepancies in hospital operation and maintenance were noted and corrective action was initiated.

2. Hospital administrative and operational procedures were revised and modernized in order to meet the basic standards of the American Medical Association, the American Hospital Association, and the American College of Surgeons. Approval of the former agencies has been procured and the third approval is anticipated.

3. Changed visiting hours from 8:00 A. M. to 4:00 P. M. to 1:00 P. M. to 4:00 P. M. in order to allow professional personnel more time to work with patients.

4. Developed and placed in operation a modern up-to-date system of reporting and following up on employee accidents (also accidents involving state vehicles).

5. Developed a system of fire calls for all hospital buildings at the Little Rock Unit in order to expedite the movement of patients in case of fire.

6. Established a position of "Safety Engineer" and began a safety program to eliminate accidents within the hospital. Job was assigned as additional duty to fire marshal.

7. Established a personnel health unit with a full-time physician in attendance. This duty was assigned as an additional duty to the physician in charge of the infirmary.

8. Established and furnished, with the aid of the Volunteer Workers at this hospital, two new recreational day-rooms and a patients' recreational center.

9. Established an employee dayroom for employees coming on and off duty and those living on the station, so that they have a place to go when off duty other than lounging in the halls of the buildings.

10. Established a six months probationary period for all employees.

11. Placed in operation a comprehensive efficiency rating program calling for quarterly ratings the first six months and yearly thereafter on all employees. (Note: Doctor and nurse program has not yet been placed in operation.)

12. Concentrated the patient's admission section of the hospital into one area so that patients can be admitted more efficiently with a smaller outlay of professional time.

13. Placed in operation a system of numbered hospital memorandums and bulletins in order to insure that all personnel are familiar with operational rules and regulations.

NURSING SERVICE

1. A new selection procedure was established for all new attendants with emphasis placed on intelligence and personality stability testing.

2. A three-year training course was established for selected attendants to train them to become psychiatric technicians. This school consisted of 780 hours of didactic lecture (200 hours of dynamic psychiatry) and 6,700 hours of supervised and graded on-the-job training.

3. Standardized all attendant uniforms throughout the hospital.

4. Initiated and carried out local psychiatric aide of

the year program and entered the winning aide from the Little Rock and Benton Unit in the National Psychiatric Aide of the Year Contest.

PROFESSIONAL SERVICE

1. Revised and modernized all psychiatric treatment techniques.

2. Revised and simplified much of the professional administrative work, thereby eliminating excessive paper work and improving care and treatment of patients at less cost.

3. Initiated project to modernize pharmacy and simplify handling of drugs in hospital.

4. Started campaign to eliminate virtually all forms of mechanical restraint and seclusion. Developed new and revised rules for application and reporting of restraint and seclusion.

5. Developed and placed in operation new professional charting procedures. Developed new forms and placed working chart on each patient on the patient's ward. The latter change allows physician to have all the information about a patient without having to leave job and go to record room.

6. Initiated and placed into effect new rules for handling criminal observation cases and the criminally insane.

7. Established a Department of Medical Rehabilitation composed of the following sections: Occupational Therapy, Manual Arts Therapy,* Educational Therapy,* Community Retraining,* Recreational Therapy, Athletic Therapy.*

8. Initiated system of assigning patients to hospital details for therapeutic reasons rather than for sheer purpose of working patients to keep hospital operating.

9. Established a council of Volunteer Workers under the direct supervision of the Chief of Medical Rehabilitation and started a compulsory 14-hour training program for all Volunteer Workers.

10. Set up and placed in operation a modern acute intensive therapy ward for women and one for men.

11. Developed and placed in operation a new procedure for reporting accidents to and assault upon patients. Appointed a special investigating officer to check into any questionable accidents and a board to investigate any severe injuries or questionable cases of mistreatment.

12. Had a comprehensive survey of dietetic system at all units made, and began to take action necessary to correct discrepancies in operation.

13. Consolidated some of the hospital dining rooms in order to improve service to patients and decrease operational costs.

14. Installed cafeteria system in all dining rooms. This system allows patients all they want to eat but cuts down on food waste. Also allows the patients to be fed more rapidly.

15. Consolidated all vegetable preparation from individual wards into central preparation room with a resultant saving in time and foodstuffs.

16. Standardized all menus so that patients and personnel receive the same food. This has decreased food cost and has improved character of food.

RESEARCH AND EDUCATION

1. Established and placed in operation a full-time department of Research and Education under the direction of a full-time physician.

2. Established a 3-year training course for attendants (see Nursing Service).

3. Established in conjunction with the local Veterans Administration Hospital a one-week training course in psy-

chiatry for student nurses in Arkansas.

4. Made an analytical study of present and future patient loads, especially as effected by older aged patients.

5. Established a professional journal club for doctors and nurses to assist in keeping them current with development in the field of psychiatry.

6. Organized and developed a medical library for the hospital and assigned a secretary to act as librarian as an additional duty. Also worked out a reciprocal exchange with the V.A. and University of Arkansas libraries.

7. Organized and placed in operation ten major research projects.

8. Developed a curriculum for a resident training program and procured teachers for the program.

9. Worked out details for psychoanalytical training of resident physicians undergoing residency training at this hospital.

10. Worked out details of procuring professional teaching equipment and supplies on an exchange basis with the University Medical School, State Health Department and the Veterans Administration Hospital.

11. Made arrangements with the State Department of Education for their assistance in setting up training courses in work simplification and dietetic employee indoctrination.

ADMINISTRATIVE

1. Moved collection section of finance next to admission office in order that finance department may contact relatives before patients are admitted.

2. Identified and officially marked all hospital supplies and equipment.

3. Placed in operation a modern system of charging out property to responsible individuals.

4. Set up a perpetual inventory system on all non-expendable equipment and supplies.

5. Developed and placed in operation a modern system for requisitioning, processing, accounting for, and charging out supplies.

6. Concentrated all business offices (including personnel) in the administration building in order to improve efficiency and cut cost.

7. Developed and placed in operation new finance, supply and raw food cost control program based on I.B.M. accounting system. This improved efficiency and effectiveness of operation and cuts operational costs.

8. Established and placed in operation a modern intra-hospital linen exchange with a resultant decrease in loss of linens while making more linens available to patients.

9. Establishment of a more modern laundry department which allows hospital to launder ALL patients' clothing.

CONSTRUCTION

1. Buildings completed: A. Little Rock—Laundry, cold storage, greenhouse, Manual Arts building—male, Manual Arts building—female, Occupational Therapy and Classroom building, salvage building, 3 garages for doctor's cottages. B. Benton—Addition to laundry, carpenter shop, T. B. building addition, 4 doctor's cottages, new incinerator building, Farm Recreational building, garbage disposal and can washing building. C. Baucum—Patient Recreation building, machine shop building, vegetable pre-cleaning and packing shed.

2. Buildings under construction: A. Little Rock—128-bed N.P.-T.B. building. B. Benton—400-bed ward building, meat curing, cold storage and cannery building.

MODERNIZATION AND REFURNISHING

1. Removed all wood tables and benches from dining rooms and replaced them with modern, plastic-covered, stainless steel tables and chairs.

2. Substituted plastic dishes and modern stainless steel

*Sections have not been completely activated.

cafeteria trays for outmoded ceramic dishes and formerly used food pans (latter pans were used as dishes by patients and were made in the tin shop, often of galvanized iron).

3. Installed eight showers in male colored ward where there was only one bathtub for 300 patients; also installed four urinals, one in each latrine, so patients could discontinue urinating in drains in middle of latrine floor.

4. Remodeled certain of bathrooms on female patient wards and added showers so that there would be at least two bathing facilities for each 175 patients instead of the usual one bathtub.

5. Constructed three modern hydrotherapy rooms on acute intensive treatment wards so that tub baths and packs could be given in accordance with the dictates of modern therapeutic practices.

6. Installed a number of ward treatment and drug rooms and furnished same with basic therapeutic equipment.

7. Installed 12 circular fire escapes on nine ward buildings in order to facilitate the removal of patients from buildings in case of fire.

8. Painted and redecorated six wards (hallways, rooms, alcoves and nurses' offices).

9. Completely repainted outside of all farm buildings (barns, slaughterhouses, etc.) at Benton Unit and painted all trim on eight ward buildings. Painted exterior of all wooden buildings at Little Rock.

10. Repaired roofs on all hospital buildings at Benton and two major buildings at Little Rock.

11. Remodeled and modernized interior and equipment of slaughterhouse at Benton so that it now meets with the approval of the State Health Department.

12. Installed new and repaired certain old equipment in the milk processing building at the Benton Unit so that pasteurizing and homogenizing plant now meets State and National Health standards.

13. Repaired and repainted administrative area in central building at Little Rock.

14. Repaired, refloored and repainted bakery at Little Rock.

15. Repainted and repaired 100 hospital beds as a vocational retraining project for patients and bought 400 new beds for the various wards of the hospital.

16. Purchased and placed in operation new plastic-covered, stainless steel furniture for certain hospital wards and dayrooms.

17. Remodeled, re-equipped and modernized the hospital morgue and post-mortem rooms.

18. Installed cold water fountains to replace water barrels and community drinking cups.

IMPROVEMENT TO GROUNDS AND ROADWAYS

1. Began a vocational training program for patients in grounds maintenance and started project of leveling lawns, planting grass and relandscaping areas at Little Rock and Benton.

2. Repaired all hospital streets at Little Rock and Benton and added one mile of new oiled roadway at Little Rock, also repaired sidewalks at Little Rock Unit.

3. Constructed four special parking areas at Little Rock Unit and eliminated "on the lawn" parking and placed road blocks to eliminate destruction of hospital lawns.

4. Invested in and placed in operation new mechanical mowing machines at Little Rock and Benton in order to improve lawn care and maintenance.

FARM IMPROVEMENTS

1. Eliminated from dairy herd 125 head of cattle that were suffering from chronic mastitis and had remainder of herd checked and treated. This action eliminated the use

of contaminated milk by hospital. Bought milk cows and replaced 52 of the eliminated herd.

2. Initiated a program of pasture improvement and soil control at Benton and Baucum. Baucum pastures were second in Pulaski County Pasture Contest.

3. Initiated and brought to virtual completion a program of drainage for the Baucum Farm with the result of improving quantity and quality of land. Drainage was done by leveling and establishment of permanent drainage ditch system.

4. Repaired, replaced, and relined virtually all fences at Baucum and installed new field fences at Baucum and Benton farms.

5. Repaired and overhauled eight farm tractors (Benton and Baucum) and various other pieces of farm machinery.

6. Purchased and placed in use: a new combine, hay baler, manure spreader and fertilizer distributor; replaced oat drills, hayrakes, disk harrow, mowing machines, etc.

7. Began a progressive program of land reclamation at Benton consisting of timber clearing, installation of permanent pastures on erodible soil, along with installation of terracing and draining.

ADMISSIONS, RE-ADMISSIONS, DISCHARGES, AND DEATHS

For the Calendar Years 1945 through 1949

	1945		1946		1947	
	M	F	M	F	M	F
First admissions	929	662	1,061	627	881	635
Re-admissions	202	168	202	137	304	230
Total	1,131	830	1,263	764	1,185	865
	1948		1949			
	M	F	M	F		
First admissions	906	647	949	633		
Re-admissions	211	192	253	211		
Total	1,117	839	1,202	844		
	1945		1946		1947	
	M	F	M	F	M	F
Discharges, Direct	151	58	233	36	218	36
Discharges, on C.D. or Escape	474	419	639	431	721	544
Deaths	359	242	294	200	399	271
Total	984	719	1,166	667	1,338	851
	1948		1949			
	M	F	M	F		
Discharges, Direct	207	39	202	37		
Discharges, on C.D. or Escape	596	530	625	626		
Deaths	243	170	249	146		
Total	1,046	739	1,076	809		

PROPOSED IMPROVEMENTS AND PROGRESSIVE CHANGES TO BE MADE AT THE ARKANSAS STATE HOSPITAL DURING YEAR 1950

HOSPITAL OPERATION

1. All reorganization and modernization programs begun in 1949 will be carried on toward completion during 1950. (See Improvements and Progressive Changes made at Arkansas State Hospital during 1949).

2. A new table of organization will be drawn up setting up divisions, services, sections and units. All divisions will be reorganized, modernized and streamlined. This should result in a more efficient and effective organization at less overall cost to the taxpayer.

3. The hospital will establish an annual intra hospital budget system based on quarterly operational activity.

4. Standard job requirements will be developed for all hospital positions and position descriptions will be written on all jobs.

5. A fire department will be established at the Benton Unit. The proper trucks will be procured, if possible, from surplus. Personnel to man the unit will be established on a volunteer basis.

6. Fire rules will be established for all wards and buildings on an individual unit basis. Rules will state what is to be done by personnel, where patients are to go, etc.

7. Standard, regular, fire drills will be held monthly on all buildings at both units.

8. A program of weekly hospital inspection will be inaugurated during 1950. Under this program, six teams composed of one doctor and one administrative chief will inspect one of six hospital districts. As teams will rotate each week, each team will have been through the entire hospital every six weeks. Deficiency reports will be turned in to superintendent.

PROFESSIONAL SERVICE

1. All progressive changes started during 1949 will be continued into 1950. Many of the new, modern programs should be completely in operation on or before the middle of the year.

2. Emphasis will be given toward enlarging and improving the Medical Rehabilitation Division at this hospital. Special emphasis will be placed on development of Community Retraining and Vocational courses in such subjects as: agriculture, horticulture, masonry, upholstery, cabinet making, sewing, etc. Every effort will be made to coordinate these training activities with the maintenance of the hospital and its equipment.

3. Additional treatment techniques will be instituted during 1950. Special emphasis being placed on group type therapies.

4. All professional administrative procedures will be brought up to the latest and most efficient standards. This will be true especially of patient records, processing, etc.

5. Admission and staffing procedures will be modernized and streamlined and present treatment center will be decentralized. This will allow patients to start their psychiatric treatment within 24 hours after entering the hospital. (At present, although the time lay before initiation of treatment has been cut from months and weeks to a number of days, better results could be obtained by more rapid institution of treatment.)

6. The dietetic department will centralize most of its kitchens and will substitute the movement of food to the various dining rooms by electrically heated food carts. This will allow for more cooks in main kitchen with more economically and better prepared food for patients.

7. Special Diet Kitchens will be organized and placed in operation on the infirmary and insulin wards so that patients needing therapeutic diets may obtain same.

8. Every effort will be made to eliminate patients from all cooking and food handling jobs due to the inherent danger that accompanies the use of patients in such jobs.

9. There will be a marked extension of the recreational therapy program and a new program of athletic therapy will be initiated. These services will be under the supervision of a paid hospital worker who will be aided and assisted by volunteers.

NURSING SERVICE

Advances made toward modernizing the nursing service during 1949 will be maintained and amplified.

RESEARCH AND EDUCATION

1. All present research and education programs will be carried forward and enlarged upon. Special attention will be paid to the School of Psychiatric Technology which has become an outstanding success.

2. A post-graduate residency training program in psychiatry will be approved and placed in operation during 1950.

3. A program for the clinical training of clinical psychologists will be initiated during 1950. This program will

be in conjunction with the University of Arkansas Psychological Training Program.

4. With the aid of the State Department of Education, this hospital hopes to establish a school for feeble minded and mental defective children during 1950.

5. An annual or biannual seminar on psychiatry and psychosomatic medicine will be given by this hospital for the physicians of the state in order to help them with problems encountered in the care and treatment of the mentally ill. A similar program has been requested by the ministers and some school teachers of the state and may be held for such groups if arrangements can be made.

6. Intensive training programs in Job Instruction Training, Job Relation Training and, Work Simplification will be given to all supervisory and sub-supervisory employees during 1950. These courses, which will be compulsory will be given with the aid of the State Department of Education.

7. A short, intensive, refresher course will be offered to all stenographers. This course will cover medical and psychiatric dictation, professional spelling, telephone technique, etc.

ADMINISTRATIVE

1. All reorganization and modernization programs begun during 1949 will be continued into 1950. Special effort will be made to make the administrative services of this hospital as effective and efficient as possible.

2. A motor pool will be established during 1950. This unit will be headed by a dispatcher and will operate on a strictly business basis. All cars will be operated on an efficient schedule and special attention will be paid to proper maintenance and repair of vehicles. This change should result in a marked improvement in efficiency and a decrease in operating costs.

3. The hospital center will be remodeled and modernized, and a system of canteen books for patients will be instituted. This will result in better service to patients and a larger income into the center operation.

CONSTRUCTION

1. Plans will be drawn for a new 1,500 bed hospital unit at Little Rock. This unit will be designed as an acute intensive treatment, diagnostic, training and treatment center.

2. The present survey of the psychiatric case load in the State of Arkansas will continue into 1950. It is hoped that when this survey is completed, an adequate estimate of future mental hospital needs will be had and that a definite answer as to where new mental hospitals should be located can be given.

3. During 1950, the new N.P.-T.B. Unit at Little Rock will be placed in operation, as will the new 400-bed ward at Benton and the Meat Curing, Canning, and Cold Storage Plant at the latter unit.

MODERNIZATION AND REFINISHING

1. A continuing drive will be made to clean up and beautify the interior and exterior of all hospital buildings. An all-out push will be made toward painting all wards and patient's rooms and extra effort will be made to install additional latrines, shower rooms, etc.

2. The milk processing building at Baucum will be repaired and enlarged and a new pasteurizing and homogenizing plant will be installed.

3. A concentrated effort will be made to procure more new furniture for all hospital wards and buildings and volunteers will be encouraged to help procure draperies and other interior decorating materials for those units. Special effort will be made to coordinate the needs of the

hospital with the vocational training of patients in furniture making, painting, furniture repair, drapery production, etc.

4. A vocational retraining project will be set up to build a 1,000-seat outdoor theatre at Little Rock and a 1,500-seat outdoor theatre at Benton. These theatres will cost little but will allow a maximum of entertainment to reach an exceedingly large group of hospital patients.

IMPROVEMENTS TO GROUNDS AND ROADWAYS

1. A special effort will be made to improve the looks of the grounds at all units. Considerable more attention will be given to grounds, landscaping and roads than has been given these objects in the past.

2. Special shrubbery and tree nurseries will be set up at Baucum and Benton in order that the hospital can be furnished with adequate material for its proposed beautification campaign.

3. As much lawn maintenance and horticulture as possible will be assigned to chronic patients as a community retraining project.

FARM IMPROVEMENTS

1. Every effort will be made during 1950 to build our beef and dairy herds back up to normal and to improve the strain of all farm animals.

2. All soil improvement and soil conservation programs will be continued on through 1950 and special attention will be paid to crop rotation, etc.

3. Maintenance of farm buildings and fences will be made an active, permanent program and will be pushed during 1950.

4. Every effort will be made to increase the quantity and quality of farm production and to decrease waste.

RECOMMENDATIONS OF THE MENTAL HYGIENE COMMITTEE

1. The Medical Society offer the services of the members of the Mental Hygiene Committee to the Crime Study Commission in working out laws covering sex crimes and chronic offenders of all types.

2. The development of an adequate psychiatric service to the penal and correctional institutions of the state, as previously recommended by the Committee.

3. The Committee recommends that a bill be drafted and submitted to the Legislature providing for the establishment of a Board of Psychiatrists to examine all criminal cases where insanity is a plea and the findings of the State Hospital examiners are contested by either the prosecution or the defense.

4. The establishment of a separate institution near one of the Teachers' Training Colleges in the state for the retarded children requiring institutional care.

5. The mental hospitals in the state are greatly overcrowded. In the future planning, to provide adequate hospital beds for the mentally ill, it is recommended that the Little Rock Unit be planned as the admission, diagnostic, acute treatment, research, and personnel training unit. This unit should not exceed 1,500 beds and should be planned in conjunction with the State Medical Center. Plans should also be prepared for the building of an additional psychiatric unit to be located in some other area of the state, the location to be designated by the Board of Control of the State Hospital. This unit should consist of approximately 500 beds for continued treatment cases of mental illness, as well as approximately 500 beds for geriatric cases requiring custodial and nursing care.

PUBLIC HEALTH COMMITTEE

E. D. McKNIGHT, Chairman

The Arkansas State Board of Health is extremely gratified that one long-sought objective was attained during

1949. No case of smallpox is recorded in Arkansas for 1949. This does not mean that no suspect cases of smallpox were called to attention, but does mean that the director of the division of communicable disease control was able to visit each such case and was helpful in establishing a negative diagnosis of smallpox.

The search for sources of infection of typhoid fever has been continued with considerable success in that fourteen typhoid carriers have been registered for the year 1949. Approximately one carrier was found for each nine cases of the disease since a total of 125 cases were reported.

Malaria and typhus fever investigations are being continued with the aid of a nurse assigned by the United States Public Health Service. Malaria reporting was, in 1949, about one-half what it had been in 1948.

Epidemics of measles and of poliomyelitis were recorded during the year, the latter disease reaching an all-time high in Arkansas, with 989 cases recorded. The case fatality rate was low; no doubt early diagnosis and hospitalization contributed materially to this low rate of less than 5 per cent.

A postgraduate seminar was arranged for the physicians of the state in January, 1949, in cooperation with the Arkansas Medical Society and the Medical School of the University of Arkansas, on the subjects of amebiasis and malaria. Officers of the U. S. Public Health Service and members of the staff of Tulane University Medical School and the University of Arkansas Medical School presented the subject matter.

In 1949, venereal disease control activities in Arkansas stressed two distinct phases which we consider of equal importance in spite of the fact that one is statistically intangible while the other can definitely measure trends in the incidence and prevalence of these diseases.

That part of our program which drew the maximum of attention was the public information campaign which used radio and billboards as the principal vehicles for the distribution of up-to-date materials concerning syphilis, easily the most dangerous of the venereal diseases.

Attractive as this campaign was—and it drew unexpectedly fine comment from public health authorities throughout the United States—it is difficult for us to evaluate its effectiveness other than to say it apparently was favorably received by the general public. It departed from the usual staid methods of public health education and flashed its way throughout the entire state on the flaming colors of Syphilis "pink," accompanied by the radio cowboy singers who told in ballad form of the dangers of contracting a venereal disease. A few of the more conservative folks labelled the program ad "undignified," but it nevertheless attracted the attention of a large portion of the population which was the desired result as outlined in the planning.

A great deal of attention was given to mass blood testing during the past year, particularly in counties where the prevalence of syphilis is high. This was a continuation of a case-finding program which began in 1947, and carried through 1948. This activity serves to find cases of syphilis by sending special blood-testing units into high prevalence areas and through publicity and community organization arranging to take as many blood specimens as possible among the general population. Following the screening process all positive tests are referred to private physicians, or to venereal disease clinics for diagnostic service. Those found infected are placed under treatment. Those who can pay for treatment are referred to private doctors. The medically indigent are sent to Hot Springs Medical Center where treatment is usually completed within five days.

Private physicians and state clinics were looking for

venereal disease as diligently in 1949 as in 1948. The overwhelming number of cases is no longer here. These diseases are being wiped out of Arkansas.

The Division of Tuberculosis Control has continued the operation of four mobile X-ray units, and aided in the operation of four stationary X-ray survey units, located at City Health Department, Little Rock; Sebastian County Health Department, Fort Smith; State Hospital for Nervous Diseases, Little Rock; and the University Hospital, Little Rock. A total of approximately 225,000 X-rays were made during the year, and approximately 700 new cases of pulmonary tuberculosis were initially discovered by this means.

The Tuberculosis Case Register has recorded approximately 2,250 cases of tuberculosis which were first reported for the calendar year 1949. These were reported from all sources. A general X-ray clinic has been held in every county in the state during the year, and approximately 450 clinics were held at various locations throughout the state. Most of the case-finding program has been devoted to the medium and smaller size cities and rural areas.

Tuberculosis case-finding will continue as the chief endeavor during 1950, but emphasis will be placed upon the block-by-block chest X-ray surveying of the larger cities in the state: Fort Smith, Pine Bluff, Helena, Hot Springs, and the combined Greater Little Rock area. These five projects would constitute a year's work for the available survey X-ray equipment.

Encouraging gains were made during the year in activities of the Maternal and Child Health Division. Two nutrition consultants and one consultant on hearing and vision testing were added to the professional staff. This is the first full year the vision and hearing testing program has been in operation and has proved to be extremely popular with the schools. The work of the two consultants on our staff is correlated with that of the Division of Speech Education of the State Department of Education and with the Junior League Speech Correction School, and follows recommendations of the Committee on EENT of the Arkansas Medical Society.

The division, in cooperation with the Pediatric Department of the University of Arkansas School of Medicine, sponsored two postgraduate refresher courses. These courses were attended by a total of 252 professional people, 171 of whom were practicing physicians. Also, arrangements were made for a joint project with the Department of Obstetrics of the Medical School.

The services of the dental fluoride team was secured from the U. S. Public Health Service for demonstration of the application of sodium fluoride to the teeth of the school children as a prophylactic measure in dental caries control. Since the beginning of the demonstrations, complete series of treatments have been given 5,604 children in eight areas in the state. Late in December, 1949, the team moved into Fayetteville, to begin the ninth demonstration.

Under midwife control service, efforts are made to weed out the most unfit midwives and to keep the others under supervision, as well as to educate the public concerning what a midwife can and cannot safely do, and to encourage patients to use supervised midwives. In this connection, 539 midwife permits were issued on recommendation of the medical directors or part-time health officers and public health nurses.

Six nurses employed in local health departments were granted scholarships for basic public health nursing study in approved university programs, four nurses on the state staff either completed or continued advanced study previously begun; ten other nurses from local departments

were granted leave for study in short workshops. In-service training programs for all nurses covering two main topics—Services for Crippled Children, and Growth and Development of the Young Child—were conducted by the state nursing staff every other month throughout the year. In May, a Cancer Nursing Institute was held for public health nurses as well as professional workers in related agencies.

The Division of Industrial Hygiene offers engineering, chemical and educational services to manufacturing and processing plants as follows:

1. Finding and evaluating occupational health hazards.
2. Recommendations for controlling the working environment, improving plant health programs and plant sanitation.
3. Educational talks, pamphlets, posters, articles and films.

During the year 1949, 182 plant visits to 167 different plants, 205 recommendations and 147 laboratory and field determinations were made affecting 20,000 industrial workers. Approximately 25 per cent of the recommendations were carried out, and it is anticipated that practically all recommended improvements will be made over a period of time.

In November, 1949, a section of industrial nurses was organized, with the aid of the State Division of Public Health Nursing and personnel of the Public Health Service. This was sponsored in an effort to improve plant medical programs.

The general program for 1950 will be basically similar; however, more emphasis is planned for educational efforts to encourage understanding of the importance of environmental control and for checking plans, before installation, for the control of toxic substances.

The promotional and engineering activities of the Bureau of Sanitary Engineering played an important part in bringing about major improvements and additions to 67 public water systems, and 22 public sewerage systems. These included the construction of complete new water systems for three towns and four new swimming pools. The cost of these improvements and additions was slightly more than \$5,000,000. This is an increase of 40 per cent over the cost of similar construction for 1948.

Plans and specifications for major improvements to 27 water systems and 23 sewerage systems were reviewed and approved. The cost of these proposed improvements is estimated at \$5,350,000 as compared to \$4,300,000 for plans for similar improvements for 1948. Construction is now in progress on a number of large water sewerage improvements, and it is believed that the amount of such improvements will far exceed that for 1949.

Periodic inspections were made of the 203 public and institutional water systems and 115 public sewerage systems.

The Bureau of Sanitary Engineering was active in helping to draft Act 472 of the 1949 Legislature which created the Water Pollution Control Commission. The Commission held its organizational meeting October 27, 1949. Application for Federal funds provided by P. L. 845 was made, and discussion of the Commission's functions conducted. Work by the Commission is limited as no funds were appropriated by the state. Work is being carried on with Federal money received in late December. At present the Commission is compiling data as to sources of pollution, checking sewage works plans, holding conferences with municipalities and industries relative to waste disposal, and working with interested parties on matters of stream pollution. Future work will be the development and activation of an overall plan for water pollution abatement.

Plans were approved by the Division of Milk Control for

seven new pasteurization plants. Plans and other information were provided for the construction of approximately 400 new dairy barns. Considerable time was spent in training seven new inspectors and giving partial supervision of sanitarians on milk sanitation. Surveys were made of the milk supplies for twenty-three cities to determine compliance with the state laws.

Pasteurized or Grade "A" raw milk is now available to almost every area of the state. This has increased the need for additional inspection service.

The main functions of the Division of Dairy Products consisted of sanitary inspection of plants, maintenance of composition standards, prevention of fraudulent practices, licensing of and collecting fees from the manufacturing plants, and the general improvement of the manufactured product from the standpoint of health and palatability.

During the year 1949 the Division of Food and Drug Control participated in all of the major programs assigned to its jurisdiction. Greater emphasis, however, was placed on the inspection of school hot lunch rooms, enforcement of the Barbiturate Act, restaurant inspections, and grocery-market inspections. Less than ten per cent of the hamburger samples picked up in the last six months have contained adulterants, as compared to seventy-five per cent of those collected two years ago.

The Malaria Control activities are financed by Federal and local funds. During the year malaria control work was in operation in fifty counties in the state, located principally in the Mississippi, Red River, Ouachita, and Arkansas valleys. A total of 109,328 houses were sprayed during the year. Mosquito control activities were carried on in twenty towns and cities under the direction of the Division.

During the year the Division of Hospitals completed the processing of sixteen projects amounting to \$6,700,000, opened bids on these projects and let contracts. Six applications were given preliminary approval amounting to approximately \$10,000,000. Five projects were completed amounting to approximately \$1,000,000.

For the year 1949, the Bureau of Vital Statistics has accomplished the following:

Brought up-to-date the microfilming program which was approximately one year delinquent.

Provided veterans with approximately 7,000 free copies and verifications of documents on file in the Bureau. This service was never rendered prior to 1949.

Worked in cooperation with the State Revenue Department, Federal Bureau of Investigation, Military Intelligence, National Guard, Girls' Training School, and Labor Division, providing these agencies with photostatic work required.

The Bureau of Vital Statistics has worked with the aim of receiving better birth and death registration in the state. The last survey by the Federal Government indicated that Arkansas had 70 per cent registration and was rated near the bottom of states listed. We expect the federal survey which is now under way to indicate a 90 per cent registration for the State of Arkansas.

LIAISON COMMITTEE WITH THE ARKANSAS MEDICAL & HOSPITAL SERVICE, INC.

(Blue Cross-Blue Shield)

G. REGINALD SIEGEL, Chairman

The one project of this Committee is to see that prepaid medical, surgical, and hospital coverage is available to every person in the State of Arkansas that desires such coverage.

The Arkansas Medical & Hospital Service, Inc., has some 30,000 persons protected at the end of November, 1949.

The enrollment has been limited primarily to groups of employed people; however, 25 county farm bureaus had been enrolled as of November 30th and it was anticipated that some 8 or 10 more bureaus would be enrolled during the month of December, 1949.

The Board of Trustees is considering a plan to extend further the program to individuals beyond those who have memberships in the farm bureaus by offering the program on a wholesale or community basis during specified periods for a previously defined area. It is hoped that this type of operation will be in effect in the early part of 1950.

It is the opinion of the Board of Trustees that Blue Cross-Blue Shield be kept in position to do the greatest good for the greatest number of the people and they hope to extend their membership to some 100,000 persons during 1950.

Blue Cross-Blue Shield is available in every county in the state and needs only the cooperation of the medical profession in each community to help institute groups. This Committee, as well as the Board of Trustees of the Arkansas Medical & Hospital Service, wishes to make it clear, however, that a membership to anyone seeking a membership will not be possible, since, in our opinion, this type of offering can be done only on the basis of a very restricted coverage and a high premium.

The Liaison Committee urges all of the members of the Arkansas Medical Society who are interested in inaugurating this service in their community to contact Mr. J. L. Redheffer, The Arkansas Medical & Hospital Service, Inc., Rector Building, Little Rock, Arkansas.

COMMITTEE ON THE AUXILIARY

LOUIS K. HUNDLEY, Chairman

In accordance with the wishes of the President and the Council of the Arkansas Medical Society during this year, the Auxiliary has assumed responsibility for a major portion of the public relations program of the Society. As co-workers on the Committee for the Extension of Medical Care, they have helped plan and implement our Grass Roots program through education of membership, distribution of pamphlets, endorsement campaign, letters to Congressmen, fair and livestock show booths, and the high school essay contest. To say only that they have done a good job is faint praise. If other Auxiliaries throughout the nation do half as good a job the battle against government control of medicine is well on the way to being won.

Under the leadership of the presidents of the past four years, our Auxiliary has grown from twenty-one component groups with 410 members to twenty-five groups with over 700 members. From more or less social groups they have developed into vital forces in our battle against socialism. Some Auxiliaries which met only semi-annually have met monthly during this crisis. Our leaders are receiving national recognition for their work and it is with pride that we note the election of Mrs. Mason G. Lawson as a vice-president of the Auxiliary to the American Medical Association.

I feel that it is imperative for the Society to continue to encourage and support the Auxiliary in carrying out its objectives. Its program must not be allowed to lag because of lack of funds or disinterest on the part of the Society. Every portion of the Auxiliary program has been developed with the full knowledge and support of this Committee. An example of the liaison between members of the executive board of the Auxiliary and the members of this Committee is the submission of written reports from sixty-five of its sixty-eight members on this year's Auxiliary program.

It is with considerable regret that I retire from the Committee at the close of this year. I feel that our Auxiliary

has accomplished much and that this work must and shall be carried on. It has been a real pleasure to see this work develop and its strength increase.

My recommendations for 1950-1951 are as follows:

1. All county medical societies which have no Auxiliary are urged to give permission and support to the immediate formation of such Auxiliaries.

2. Allowance of \$150.00 for printing of the minutes and reports for the year. (Cost averages \$175.00.)

3. Travel allowance of \$500.00 for the President and \$100.00 for the President-Elect should be continued on a reimbursement basis.

4. Allowance of \$25.00 for membership in the Arkansas Legislative League, provided that the Arkansas Medical Society continues its membership.

5. Representation on the Committee for the Extension of Medical Care on a councillor district basis. (One Auxiliary member from each district.)

TRAVEL SCHEDULE, PRESIDENT OF AUXILIARY TO ARKANSAS MEDICAL SOCIETY

April 19-22—Midwest Health Conference, Kansas City.

May 10—First Councillor District Meeting, Tyrone.

May 16—Fourth Councillor District Meeting, Pine Bluff.

June 5-10—Annual Meeting, Auxiliary to the AMA, Atlantic City, N. J.

June 20—Auxiliary to the Southeast Arkansas Medical Society, McGehee.

June 23—Pope-Yell County Medical Society and Auxiliary, Russellville.

Sept. 13—Auxiliary to Garland County Medical Society, Hot Springs.

Sept. 14—Arkansas Health Council, Little Rock.

Sept. 30—Executive Board, Auxiliary to Arkansas Medical Society, Little Rock.

Oct. 9-13—Conferences, AMA offices; Whitaker & Baxter, Chicago, Ill.

Oct. 14—National Conference on Physicians and Schools, Hyde Park, Ill.

Oct. 17—Fourth Councillor District Auxiliary, Monticello.

Oct. 19—Auxiliary to Pulaski County Medical Society, Little Rock.

Oct. 27—Joint Meeting, Auxiliaries to Bowie-Miller, Little River and Sevier County Medical Societies.

Nov. 2-4—Conference of Presidents and Presidents-Elect, Auxiliary to the AMA, Chicago, Ill.

Nov. 14-16—Auxiliary to Southern Medical Association, Cincinnati.

Dec. 1—Arkansas Health Council, Little Rock.

Dec. 2—Auxiliary to Jefferson County Medical Society, Pine Bluff.

Dec. 7—Auxiliary to Union County Medical Society, El Dorado.

Jan. 9—Auxiliary to Sebastian County Medical Society, Fort Smith.

Jan. 17—Auxiliary to Arkansas County Medical Society, Stuttgart.

Feb. 1—Auxiliary to Greene-Clay County Medical Society, Paragould.

Feb. 1—Craighead-Poinsett County Medical Society and Auxiliary, Jonesboro.

Feb. 10—Executive Board, Auxiliary to Arkansas Medical Society, Little Rock.

Feb. 21—Auxiliary to Columbia County Medical Society, Magnolia.

March 2—Auxiliary to Ouachita County Medical Society, Camden.

March 9—Auxiliary to Washington County Medical Society, Fayetteville.

In addition to the aforementioned trips I have scheduled visits to Auxiliaries to the Jackson, Hempstead, Monroe, and Hot Spring County Medical Societies. Because of conflicting engagements I was unable to accept the invitations of the Ninth Councillor District and Second Councillor District. I have attended twenty-two committee meetings on Auxiliary business in Little Rock, and have been present at all meetings of the Committee for the Extension of Medical Care.

REPORT OF THE AUXILIARY TO THE ARKANSAS MEDICAL SOCIETY

The Auxiliary to the Arkansas Medical Society has celebrated its Silver Anniversary year by achieving a greatly increased membership; by intensifying its effort in every field of the established program; and by formulating and implementing a program of public relations aimed at combatting compulsory national health insurance.

Following the April convention the Auxiliary had its first workshop for training state officers and committee chairmen, and county presidents. Work books containing detailed plans for the year's activities were distributed. Much of the integration of state and county auxiliary programs may be attributed to this session.

At the request of Dr. Euclid Smith, the Auxiliary assisted in establishing the Arkansas Health Council. The president attended the Midwest Health Conference and later visited the offices of the AMA where the Bureau of Health Education provided much material to aid in this project. Dr. D. A. Dukelow was sent to Arkansas by the AMA to assist lay groups in their first state-wide rally for setting up the Council.

The Auxiliary is approaching the goal of \$5,000 for the Ilse F. Oates Student Loan Fund, with \$4,053.12 now in the fund, and contributions from several Auxiliaries still unreported. The seventy-fifth medical student has recently received a loan from this source. Two loans have been made to student nurses from the Martha Harding Gann Memorial Loan Fund.

Each Auxiliary in the state has made plans for the observance of Doctor's Day, and Governor Sid McMath has proclaimed March 30th for this occasion. Tributes will be paid over the radio, in the newspapers, and from the pulpit to members of the profession. Although many social affairs will be given to honor physicians, the Auxiliary is emphasizing this date as an opportunity for the establishment of better understanding between the doctors and the laity.

Attempting to attain a unified, systematic organization each component group has been urged to adopt a Constitution and By-Laws patterned after that of the state Auxiliary. Each county organization has been advised of the necessity for an advisor from its county medical society.

The Auxiliary continued to contact organizations throughout the state for contributions for the Erle Chambers Memorial Library Fund, which purchases books for the libraries at the tuberculosis sanatoria.

Auxiliaries furthered their public relations programs by assisting volunteer and tax-supported health groups in the tuberculosis screening program, Seal Sale campaign, Red Cross, cancer control program, March of Dimes, and PTA pre-school roundups. They provided material for health programs before civic clubs and PTA groups.

Hygeia promotion has placed that magazine in many doctors' waiting rooms, beauty parlors, schools, and libraries.

A history of the first twenty-five years of the Arkansas Auxiliary is being compiled by the historian, and biogra-

phies of pioneer doctors are nearing completion.

The work of the Auxiliary on the program for the Extension of Medical Care was our outstanding endeavor. Members received information on pending legislation, on Blue Cross-Blue Shield, and the AMA Twelve Point Program. Pamphlet distribution covered drug and grocery stores, beauty parlors, libraries, and club meetings. Many groups purchased copies of "The Road Ahead" for school and public libraries.

An endorsement campaign was conducted among women's groups throughout the state, and letters were secured from members and their friends on legislation affecting medicine. Booths were set up at thirty county fairs, two district livestock shows, and the state livestock show to distribute campaign material. There were booths at the Tri-District Lions' Convention, the Business and Professional Women's nine-state conference at Hot Springs, and at the Arkansas Farm Bureau Convention. Approximately 500,000 pieces of literature were given out at these booths.

An Essay Contest was conducted in high schools throughout the state under the auspices of the Auxiliary. Results will be announced at the state convention.

To have served as the leader of 700 women devoted to the cause of independent medicine is a privilege for which I shall ever be grateful. It is with sincere appreciation for the effort of each member that I summarize our accomplishments of 1949-1950. We have received the utmost in encouragement and assistance from our Advisory Council.—(Mrs. Louis K.) Jeane D. Hundley, President, Woman's Auxiliary to the Arkansas Medical Society.

RURAL HEALTH COMMITTEE

JOE W. REID, Chairman

The Rural Health Committee during the past year has:

1. Sponsored exhibits at county fairs throughout the state and distributed literature supporting the private practice of medicine and the state Blue Cross-Blue Shield program.
2. Attended all meetings in the state which were held to organize the Arkansas Health Council.
3. Sent representatives to the Fifth Annual Conference on Rural Health, sponsored by the American Medical Association, held at Kansas City in February, and on the program of which were three Arkansans representing state lay organizations.
4. Formulated plans for the launching of a physicians' placement bureau to locate doctors in the state where such a need exists.

Recommendations:

1. Increased Society participation in the organizing of county health councils.
2. The full cooperation with and support by the Society of the University of Arkansas Extension Department on Health Education on behalf of our rural people. In addition, a vote of appreciation by the Society to Mr. Aubrey Gates and Miss Helen Robinson, health specialists with the Extension Department, for the outstanding work they have done in organizing the Arkansas Health Council.
3. Increased attendance of Society members at the Annual Conferences on Rural Health.

POSTGRADUATE STUDY COMMITTEE

A. D. GARNER, Chairman

At the annual meeting of the Arkansas Medical Society in April, 1949, it was decided that the Committee on Postgraduate Medical Study should be transferred to the Committee on Medical Education and Hospitals as a subcommittee. This transfer was accomplished and approved by vote in the House of Delegates. On September 14, 1949,

it was announced that the Committee should consist of Dr. A. D. Garner of Paragould, Dr. Jeff Banks, and Dr. D. A. Rhinehart of Little Rock, and Dr. E. J. Stroud of Jonesboro.

The Committee sponsored a postgraduate course in Pediatrics given by the Department of Pediatrics of the University of Arkansas School of Medicine under the supervision of Dr. William A. Reilly at Little Rock on October 31 and November 1, 1949. The Committee collaborated with the First Councillor District Medical Society in presenting six outstanding medical speakers and the president of Hendrix College at an afternoon and evening meeting in Paragould, November 8, 1949. Dr. James Costen of St. Louis opened the meeting with a paper on the Morphology and Diagnosis of Tumors of the Larynx. Dr. Paul Mahoney of Little Rock discussed the paper. Dr. Thomas Findley of New Orleans introduced the subject of the Management of Generalized Edema, and this paper was discussed by Dr. Richard Ching of Memphis. Dr. Alton Ochsner of New Orleans spoke on the Diagnosis and Treatment of Bronchiogenic Carcinoma. Discussion on this subject was led by Dr. Duane Carr of Memphis. Supper for the Doctors and their guests was served at the Kingsway Club. In the evening Dr. Matt Ellis, president of Hendrix College, addressed an open meeting of the doctors and lay people of the community. Both the Pediatrics course in Little Rock and the First Councillor District Meeting in Paragould were well attended.

The Department of Pediatrics of the University of Arkansas School of Medicine has scheduled another postgraduate course in Pediatrics for March 13 and 14, 1950, in Little Rock. The Department of Obstetrics and Gynecology of the University School of Medicine is planning to hold a Postgraduate Course in Obstetrics and Gynecology in Little Rock, March 27, 28, and 29, 1950. Registration for the latter course will be restricted to a small number of physicians so that study may be intensive and well supervised.

Recommendations:

1. It is recommended that Committee appointments for the following year be announced in April immediately after the Annual Meeting of the Society so that the chairmen and members of the Committees may accomplish something in the way of planning and organization before autumn. Since appointments are made September 14th, and final committee reports must be in by February 10th of the following year, little time for committee work is allowed.

2. It is again recommended that ten members be appointed to the Committee on Postgraduate Study, two members for five years, two members for four years, two members for three years, two members for two years, and the remaining two members for one year each. It is recommended that two new members be appointed each year to replace those retiring, newly appointed members to serve five years each. This arrangement will give a more permanent organization so that long-range plans for postgraduate medical study may be considered. It is further recommended that two members of the Committee be appointed from each of the four corners of the state and the remaining two members be appointed from the central part of the state. This will allow the local committee members to set up postgraduate study sessions in their own part of the state, thus bringing speakers nearer to those physicians who may be interested in attending the meetings.

CANCER CONTROL COMMITTEE

HENRY G. HOLLENBERG, Chairman

The Committee on Cancer Control has worked throughout the year with the complete cooperation of many other

agencies and individuals with whom it is associated. Prominent amongst these are the Arkansas State Cancer Commission, the Arkansas State Cancer Society with its Field Army and the various Cancer Clinics and their physicians throughout the state.

Your Committee has arranged four Seminars which were held in November in Fort Smith, Texarkana, Jonesboro and Little Rock. Prominent out-of-state speakers held these Seminars which on the whole were satisfactorily attended and were thought to be quite successful. This type of Seminar was tried this year for the first time and it is thought that something of the same sort should be continued each year to come. Along the same line we have been instrumental in obtaining the services of a prominent speaker for the state meeting to be held in April, 1950. In carrying out the above two programs we are indebted to the State Cancer Commission for financial assistance and to many physicians and other agencies for the real success and management of the program.

It is felt that through the many agencies throughout the state carrying on this work that every individual in the state having cancer can obtain modern and adequate therapy of all types regardless of his financial condition.

MATERNAL WELFARE COMMITTEE

I. FULTON JONES, Chairman

The Maternal Welfare Committee held a meeting September 18, 1949, Albert Pike Hotel, Little Rock, Arkansas. At that time, Dr. Willis E. Brown, Professor and Head of Department of Obstetrics and Gynecology, University of Arkansas School of Medicine, offered a plan of graduate education through the Medical School and Public Health Services for Obstetrical Refresher Courses. This was approved by the Committee and the first Bedside Refresher Course will be held in March, 1950. It is expected that about fifteen men will receive this course, which will last three days.

Dr. Brown, also, offered Consultation Services by telephone or even actual bedside by his staff, to any interested physician in Arkansas.

The Committee was pleased to note that maternal deaths in the past two years showed a further decrease in maternal mortality. Committee feels that any further decrease in maternal mortality will have to come after the needs of maternal hospitalization for indigents throughout the state has become possible.

CHILD WELFARE COMMITTEE

JOHN T. GRAY, Chairman

The Committee on Child Welfare met on several occasions during 1949-50 with a quorum being present at each meeting. A number of urgent problems in child health and welfare was presented to the Committee and the following action with respect to each problem was taken:

PREMATURITY

The Committee recommends that in order for the Statistical Division of the State Health Department to secure adequate statistics on premature births that all physicians be urged to complete birth certificates to show accurate birth weights.

SCHOOL HEALTH SERVICES

It is the feeling of this Committee that the Society should endorse school health programs and urge school systems to establish and operate such a program. To this end the Committee recommends that each county medical society appoint a school health committee from among its members to advise with and provide medical guidance and leadership to any school system contemplating the establishment of, or having in operation, a school health

program, and to work with the local health department in this program. Such committeemen would also serve, it is hoped, as representatives of the medical profession on community health councils, school advisory health councils, or as school physicians.

POLIOMYELITIS

On December 15, 1949, a Report of the Special Committee on Poliomyelitis of the Pulaski County Medical Society was received by this Committee with the request that all aspects of the report be carefully reviewed and a report be made to the Society as to its adoption.

This report concerns the general methods of handling patients with acute poliomyelitis when referred to the Little Rock area, and sets up a fee schedule for the care of the acute cases and also fees for convalescent care and subsequent pre-operative and post-operative care. These fees to be paid by the various county chapters of the National Foundation for Infantile Paralysis, Inc., for only those patients considered medically indigent. Representatives of the NFIP from the state and national level advised this Committee of their policy regarding medical services. They wish to assist in every possible way the mobilization of equipment and personnel to provide the best medical care for the polio patients at all times, particularly during an epidemic and in so-called epidemic areas. Where the polio patient has need of financial assistance the county chapter may agree to pay all or part of the cost of hospitalization, nursing care, drugs, ambulance, braces, physical therapy, or convalescent care. A family thus relieved of this tremendous cost would, it is anticipated, be in a position to pay their own doctor bills.

With regard to the report under discussion, the representatives of NFIP were generally in agreement with paragraphs 3 and 4. Paragraphs 1 and 5 of the report disregards those cases known to be medically indigent and at present are treated by the Crippled Children's Division of the State Department of Public Welfare. It is the Committee's opinion that NFIP would prefer this arrangement to continue, with some provision being made to compensate the physicians concerned. They object to paragraphs 5, 6, and 7, stating the schedule of fees is too high and suggest a fee schedule not to exceed the South Dakota plan.

In view of the objections to the Report of Special Committee on Poliomyelitis of the Pulaski County Medical Society by the NFIP, this Committee recommends that the report not be adopted by the Arkansas Medical Society.

In lieu of the report under discussion, your Committee recommends that the following statement of policies with regard to care and treatment of infantile paralysis be approved by the Society:

1. Professional individuals and groups, hospitals, and official state and voluntary agencies have responsibilities to the patient with poliomyelitis and should coordinate their energies and resources in a unified approach to the problem of making care available to those who need it. Activities of such groups whether they be public, voluntary, or private, local, or state-wide, can be directed by the State Poliomyelitis Planning Committee which was organized and functioned in the 1949 epidemic.

2. The program of care should be so planned as to maintain contacts between patient and family and in such a manner that it preserves the doctor-patient relationship. Cases of known or suspected poliomyelitis referred to a distant treatment center, should be directed to a specific hospital, physician, or agency by the family physician if at all possible. Only one physician should have the primary responsibility of the patient at all times. Other physicians

seeing the case should be on a consultant basis.

3. Hospital facilities for acute and convalescent care should be increased by encouraging the general hospitals in the larger cities of the state to accept and care for poliomyelitis patients.

4. The following schedule of fees be submitted to all concerned as a fair and adequate reimbursement for services to the medically indigent poliomyelitis and poliomyelitis suspect patient whose cost of care is underwritten by the NFIP county chapters.

Hospitalization: County chapters of NFIP will pay hospitals for care of poliomyelitis patients at inclusive reimbursable cost rates as maximum payment, except in those instances where it is agreed that a negotiated rate (less than cost) is in order.

Convalescent Care: County chapters of NFIP will pay convalescent homes for care of poliomyelitis patients at inclusive reimbursable cost rates as maximum payment, except in those instances where it is agreed that a negotiated rate (less than cost) is in order.

Nursing Care: Except in unusual circumstances, nursing service is to be a part of the inclusive care provided by hospitals. In these unusual instances the usual rates of private duty, or practical duty nursing fees could not be exceeded.

Physical Therapy: Received as in-patient care this service would be absorbed in the inclusive rate of hospital or convalescent center. For physical therapy given as an out-patient by a qualified physical therapist the fee shall not exceed \$2.00 per treatment.

Physicians: The physician's fee for the care of an anterior poliomyelitis patient, not developing bulbar complications, shall not exceed \$50.00 for the first full month of illness, or \$3.00 per visit, not to exceed \$12.00 per week during the acute state if the patient be dismissed prior to the end of the first full month.

The physician's fee for the care of an anterior poliomyelitis patient developing bulbar complications shall not exceed \$85.00 for the first full month, or \$3.00 per visit not to exceed \$21.00 per week during the acute stage if the patient be dismissed prior to the end of the first full month.

The physician's fee for hospital supervision of a patient subsequent to the first month of illness shall not exceed \$15.00 per month. (An exception to this provision should be considered by local chapters in certain rare instances when the development of respiratory or other unusual complications make additional care necessary.) In these cases the doctor will be asked to set forth, with sufficient clarity, an explanation of such additional services.

When consultation is necessary, the consultant, who must be a licensed physician and surgeon qualified in his particular specialty, may be chosen by the attending physician. A fee of \$5.00 will be paid for initial and subsequent visits, such fee not to exceed \$12.00 for any one week except as shown above.

Surgical fees include the necessary pre- and post-operative care and may be over and above the honorarium received from the Crippled Children's Division for general supervision of these cases.

For major operative procedures requiring anesthesia and open surgery, regardless of the number of procedures done during the operation, the surgeon's fee shall not exceed \$75.00.

Anesthesia: The anesthetist's fee shall not exceed \$10.00 for the first hour, nor more than \$5.00 per half hour thereafter.

Follow-up care will be accomplished through the clinics of the Crippled Children's Division at no cost to the county chapter or families.

Physicians will be expected to itemize accounts for which the National Foundation Chapters may agree to accept responsibility and the acceptance of payments made in keeping with this schedule shall be considered as payment in full for such services.

COMMITTEE FOR LIAISON WITH THE STATE HOSPITAL FOR NERVOUS DISORDERS

R. V. McCRAY, Chairman

After a conference with other members of the Committee and investigation of affairs and conditions we find the State Hospital to be in good state and relations with other members of the profession.

There are probably some changes that could be made to better conditions which will be looked into at a later date. At this time we have no definite recommendations to make.

LIAISON COMMITTEE WITH THE ARKANSAS STATE BOARD OF HEALTH

W. B. GRAYSON, Chairman

The State Board of Health in Arkansas was established by Act No. 96 of the 1913 Legislature. This Act was entitled "An Act for the Better Protection of the Public Health, and for Other Purposes." The power was conferred upon the State Board of Health to make "all necessary and reasonable rules and regulations for the protection of the public health, and for the general amelioration of the sanitary and hygienic conditions within the State, and for the suppression and prevention of infectious, contagious, and communicable diseases, and for the proper enforcement of quarantine, isolation, and control of such diseases."

The general consensus in Arkansas as well as in other states is that this can best be accomplished through the establishment of full-time local health departments, adequately staffed with well-trained physicians, nurses, sanitarians, and other ancillary public health workers. At the present time there are two city health units, eight single county health units and seventeen district health units of from two to five counties each, and ten counties organized for nursing service only. The State Board of Health has not been able to establish and maintain adequate local health service throughout the state because of the following:

1. We have not been able to secure the services of professional personnel, principally physicians and nurses, because our salaries have not been high enough to attract them.

2. Local units of government have not been able to bear their proportionate share of the expenses of conducting a local health program.

As of January 1, 1950, we had only nine full-time local health officers and one assistant health officer in the City of Little Rock. To adequately cover the state we would need a minimum of thirty-one full-time local health officers. At the present time our salary ranges from \$5,100 per annum for the untrained physician with no experience in the field of public health to \$6,900 per annum maximum for the physician with a year of postgraduate training in public health and several years' experience. The salary range in surrounding states for similar positions is from \$6,000 to \$6,600, up to \$7,500 to \$8,400 per annum. On January 1, 1950, we had a total of 100 full-time public health nurses. We would need at least 400 public health nurses to adequately serve the state. In addition to the above we need approximately 130 sanitarians and 130 clerical workers. At present we have fifty-four sanitarians and eighty-four clerical workers. In at least three areas

of the state there is a need for the service of a full-time sanitary engineer. The services of full-time veterinarians are also needed in two or three places. In addition to the above, there is a need for public health educators and nutritionists, and also a number of full-time dentists and dental hygienists. The services of physicians are also needed on part-time basis to conduct pre-natal clinics, well-child conferences, and venereal disease clinics.

The above named personnel and services can be provided for approximately \$1.50 per capita. At the present, approximately \$981,000 is being expended for local health service in the state.

In order that local units of government might provide their proportionate share of the expenses of conducting a local health program, there needs to be a provision made for them to vote a millage specifically for public health purposes.

The greatest single need is that of securing the services of physicians as full-time health officers, and this problem can only be solved by providing better salaries.

HOSPITAL RELATIONS COMMITTEE

A. S. KOENIG, Chairman

Upon the recommendation of the American Medical Association that state societies appoint committees on Hospital Relations, this Committee was so appointed this year for the first time in the history of the Arkansas Medical Society. With the increased participation of hospitals in offering medical services to patients, it has become mandatory on both national and state levels that the legal and ethical limits of medical practice be clearly defined, and in this respect also, the responsibilities of the physician and the hospital should be separated. In as much as the Committee on Hospital Relations is a new one, its members felt that our objectives for the year 1949-1950 were twofold. Our first responsibility was to propose for adoption by the House of Delegates of the Arkansas Medical Society, a statement of policy which is to be considered the official attitude of the Arkansas Medical Society toward physician-hospital relations. Secondly, to discuss ways and means of settling differences of opinion and grievances which may arise between hospitals and physicians in the State of Arkansas.

The Hospital Relations Committee has been in correspondence with the office of the Attorney General of Arkansas in an effort to obtain a clear definition as to what constitutes the legal practice of medicine, and whether or not hospitals legally have the right to offer medical services. The correspondence has been particularly concerned with the specialties of Pathology, Radiology, Anesthesiology and Physical Medicine, in as much as these are the usual medical services offered by hospitals. As yet no final opinion has been forthcoming from the Attorney General, but through further conferences it is our hope that we may have a definite, conclusive opinion as to the legal status of these specialties in the state. The following preliminary opinion, however, has been rendered to this Committee by the Attorney General's office: "In view of the fact that requirements necessary to obtain a license to engage in the practice of medicine in this state are of a personal nature, all of the statutes requiring some quality or characteristic which would not be found in a corporation, we feel that our Supreme Court would adopt the holding in the Kerner case above cited; and it is therefore our opinion that the statutes pertaining to the issuance of licenses for the purpose of practicing medicine could not be extended to include a corporation. Therefore, a corporation, as such, being unable to obtain a license, would not be permitted to engage in the practice of medicine."

The ethical position of the physician in relation to the

practice of Pathology, Radiology, Anesthesiology and Physical Medicine has been clearly defined in the report of the Committee on Hospitals adopted by the House of Delegates of the American Medical Association June 6, 1949. In this report it is stated that the Principles of Medical Ethics of the American Medical Association conclude that the overall policy of the American Medical Association shall be that it is unethical for any lay corporation to practice medicine and to furnish medical services for a professional fee which shall be so divided as to produce profit for a lay employer, either individual or institutional, including hospitals and medical schools.

It has become rather a common practice in the present-day management of hospitals to divert profits from Laboratory, X-ray Departments, Anesthesiological and Physical Therapy Departments to cover deficits existing in other portions of the hospital. In some instances this has resulted in exploitation of these departments in the effort to provide a larger margin of profit to help defray expenses of other departments in the hospitals.

Oftentimes fees for the services rendered by the departments of Radiology, Pathology, Anesthesiology and Physical Medicine are established without consultation with the head of the department or the Medical Staff. Also, physicians who head these various departments are employed or discharged without consultation with the Medical Staff.

In view of the ethical principles of the American Medical Association stated above, the Committee also felt that in insurance programs, particularly the Blue Shield and Blue Cross programs which are partially sponsored by physicians, that hospitalization benefits should cover hospital services only. In the present Blue Cross insurance policy which is being issued in Arkansas, provision is made for Laboratory, X-ray and Anesthesiological services to be provided by the hospital. Although it is not the intent of the Blue Cross plan to provide these services for diagnostic purposes on patients who otherwise would be treated as private out-patients, the fact that the coverage is included in the policy has a tendency to make hospitalization for diagnostic purposes more desirable for the insured. This Committee feels that offering these services under the Blue Cross coverage is wrong for two reasons: first, it has a definite tendency to be discriminatory against the private individual practice of Pathology, Radiology, Anesthesiology and Physical Medicine; secondly, it has a tendency to unnecessarily fill hospital beds which are badly needed for patients actually requiring hospitalization.

After due consideration the Committee on Hospital Relations makes the following recommendations to the House of Delegates of the Arkansas Medical Society with the suggestion that they be adopted as the official policy of the Society:

1. That the Arkansas Blue Cross policy shall provide payment for hospital services only. Payments for all of the medical services including Pathology, Radiology, Anesthesiology and Physical Therapeutic services shall be included in the Blue Shield policy.
2. That so far as possible the medical costs of hospital care be separated from the non-medical costs, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient.
3. That a basic principle in an establishment of charges should be that each department be self-supporting. This principle should be so applied that neither the hospital nor the physician rendering the service shall exploit the patient or each other.
4. That fees for medical services, which are collected by the hospitals, be established with a representative com-

mittee of the Staff to include the Head of the Department, the Administrator and the Executive Medical Staff.

5. That the basis of financial arrangement between hospitals and physician may be salary, commission, fees, or such other method as will best meet the local situation with due regard to the needs of the patient, the community, the hospital and the physician.

6. That bills for all medical services be rendered in the name of the physician or physicians performing the services.

7. That the heads of departments of Radiology, Pathology, Anesthesiology and Physical Medicine be only selected by hospitals in accordance with the accepted methods of appointment of physicians to staff positions in other specialty services of the hospital. Their qualifications for their position should be subject to the approval of the Governing Medical Staff. By the same token, no physician heading a department of Radiology, Pathology, Anesthesiology or Physical Medicine shall be separated from staff appointment by the Administrator or Governing Board of a hospital without the knowledge or approval of the Governing Medical Staff.

In respect to the second objective of the Committee on Hospital Relations, it was felt that any grievances or differences of opinion which might arise between physicians and hospitals should first be discussed at the local level with the assistance of the local County Medical Society. For this reason it is suggested that where indicated, committees on Hospital Relations should be established within local County Medical Societies. The Committee on Hospital Relations of the State Society will be available to receive complaints from any physician, hospital, medical organization or any other interested person or group with reference to professional or economical relations existing between Doctors of Medicine, hospitals or medical schools. If settlement of differences of opinion fail at the local county level, upon receipt of the written complaint by the state committee, the matter shall be investigated and acted upon in such a manner as the Committee may decide and in accordance with regular and existing modes of procedure. If an arbitration cannot be effected by the Committee on Hospital Relations or the Council of the Arkansas Medical Society, the matter will be referred to the Judicial Council of the American Medical Association. The American Medical Association has stated that if a hospital or other lay group is found guilty or will not cooperate within ethical and legal limits, the Judicial Council shall order the withdrawal of the Association's approval of the institution concerned.

The recommendations herein included have been submitted to the Arkansas Society of Radiology and the Arkansas Society of Clinical Pathologists and were unanimously endorsed by both of these organizations.

The Chairman wishes to thank the members of the Committee on Hospital Relations, as well as the Chairman of the Committee on Medical Education and Hospitals and Officers of the Arkansas Medical Society for their interest and cooperation.

MEDICAL EDUCATION COMMITTEE

JAMES M. KOLB, Chairman

The Committee on Medical Education of the Arkansas Medical Society met with Dr. W. C. Langston, Acting Dean of the University of Arkansas School of Medicine, on Thursday, January 26, 1950, at 10:00 a. m. The following members were present: Dr. James M. Kolb, Chairman, of Clarksville; Dr. A. F. Hoge, of Fort Smith; Dr. H. W. Thomas, of Dermott; Dr. G. W. Reagan, of Little Rock; and Dr. C. C. Long, of Ozark. Members absent were: Dr. J. W. Amis, of Fort Smith, and Dr. G. Murphy, Jr., of El Dorado.

After considerable discussion of affairs and problems at the School of Medicine, decision on the following points was reached as outlined:

1. That this Committee recommend to the House of Delegates that they oppose any and all forms of subsidization of medical education which will in any way involve federal control of the medical agency concerned.

2. That this committee recommend to the House of Delegates that they lend all possible efforts to the immediate construction of the new medical center in the securing of adequate funds for the operation.

3. That the membership of the Arkansas Medical Society be requested to use this Committee as a proper channel by which to refer any suggestions, counsel, etc., concerning the School of Medicine.

4. That a copy of all publications, committee appointments, etc., of the Arkansas Medical Society be sent to the Dean of the School of Medicine for his information and record.

5. That the School of Medicine attempt to institute a better system of referral of patients to the University Hospital and the Isaac Folsom Clinic.

6. That this Committee urge the House of Delegates to use every possible means to have Act 346 repealed, which is the law requiring admission to the School of Medicine on a Congressional District basis, for the following reasons:

a. The system is frowned upon by the rating inspectors of the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges as it would cause deterioration of the quality of students.

b. Necessary for the School of Medicine to have the finest quality and talent for medical students.

c. Inferior students later fail, which endangers the medical program and wastes the State's money.

7. That this committee wishes to go on record commending the present administration for the efficient manner in which they are handling the situation.

The following statistics concerning the operation of the School of Medicine and University Hospital were obtained from the authorities of the School of Medicine:

1. Number of applicants, session 1948-1949—232.
2. Number of students accepted in freshman class, session 1948-1949—92.
3. Number of students who failed during session 1948-1949: Freshman year, 11; Sophomore year, 2; Junior year, 1; Senior year, 0; total, 14.
4. Number of graduates, session 1948-1949—54.
5. Number of out-patient visits in 1948-1949—67,279.
6. Number of patients in University Hospital in 1948-1949—6,157.
7. Per diem cost for hospital patients in 1948—\$9.61.
8. Number of full-time faculty members in 1948—31; 1949—42.

PRELIMINARY PROGRAM

SEVENTY-FOURTH ANNUAL SESSION ARKANSAS MEDICAL SOCIETY

Goldman Hotel
Fort Smith, Arkansas
April 17, 18, 19, 1950

Sunday, April 16th, 8:00 P. M.

The Council will meet in session preliminary to the Annual Session at the Goldman Hotel.

Monday, April 17th, 9:30 A. M.

Invocation.

President's Address—Euclid M. Smith, M. D., Hot Springs.
OBSTETRICS-GYNECOLOGY SYMPOSIUM—Charles R. Henry, M. D., Little Rock, Moderator.

"Prolonged Labor"—F. E. Whitacre, M. D., Memphis, Tennessee.

"Saddleblock and Regional Anesthesia in Obstetrics"—H. E. Schmitz, M. D., Chicago, Illinois.

"Cancer of Cervix and Corpus Uteri"—A. N. Arneson, M. D., St. Louis, Missouri.

"Conservatism in Gynecology"—E. C. Hamblen, M. D., Durham, N. C.

"Endocrine Therapy in Gynecology"—E. T. Ellison, M. D., Texarkana, Texas.

QUESTION-ANSWER LUNCHEON—Willis Brown, M. D., Little Rock, Moderator.

Monday, April 17th, 1:30 P. M.

CARDIO-VASCULAR SYMPOSIUM

"Diagnostic Criteria in Arteriosclerotic Heart Disease"—B. B. Wells, M. D., Little Rock.

"Cardiac Function and Emotional States"—Louis F. Bishop, Jr., M. D., New York City, New York.

"Heart Catheterization, Its Application to Cardiac Diagnosis with Special Emphasis on Congenital Heart Disease and Mitral Stenosis"—Don W. Chapman, M. D., Houston, Texas.

"Practical Aspects of Rheumatic Fever"—Joseph Rosenzweig, M. D., Hot Springs.

"Use of Anticoagulants in Myocardial Infarction"—(to be announced).

4:00 P. M.

HOUSE OF DELEGATES.

Monday Evening, April 17th, 6:30-9:30 P. M.

Open House by Members of the Sebastian County Medical Society:

Dr. and Mrs. J. Kenneth Thompson

Dr. and Mrs. Fred H. Krock

Dr. and Mrs. A. S. Koenig

Dr. and Mrs. T. P. Foltz

Tuesday, April 18th, 9:30 A. M.

"Infectious Mononucleosis"—G. H. Butler, M. D., Fayetteville.

"Urological Problems in Children"—Barney P. Briggs, M. D.; James Headstream, M. D.; H. Fay H. Jones, M. D., Little Rock.

"The Dysenteries"—Frank M. Acree, M. D., Greenville, Mississippi.

"State Hospital Problems in the Mid-West"—E. Rogers Smith, M. D., Indianapolis, Indiana.

"What the University of Arkansas Department of Pathology Means to the General Practitioner in Arkansas"—Anderson Nettleship, M. D., Little Rock.

11:30 A. M.

MEMORIAL SERVICE.

Tuesday, April 18th, 1:30 P. M.

"Carcinoma of the Colon and Rectum"—S. W. Hawkins, M. D., Fort Smith.

"Established Factors in Carcinogenesis with Particular Reference to a Continuing Cause or Viral Agent"—Wm. O. Russell, M. D., Houston, Texas.

"Surgical Aspects of Breast Tumors"—W. G. Cooper, Jr., M. D., Little Rock.

"Blue Cross Reports"—(to be announced).

"Post-Operative Complications of Gall Bladder Surgery"—Col. W. W. Nichols, Army and Navy General Hospital, Hot Springs.

"The Acute Abdomen"—Frank Kumpuris, M. D., Little

Rock.

Tuesday Evening, April 18th, 7:00 P. M.

Buffet Supper and Dance. Host, Sebastian County Medical Society.

Wednesday, April 19th, 9:30 A. M.

"Translumbar Aortography, Its Value in Obstructive and Congenital Renal Disease"—Watterson Reagan, M. D., Little Rock.

"Tularemia"—Capt. Richard R. Taylor, Army and Navy General Hospital, Hot Springs.

"Function of the Eye Bank and the Technique of Corneal Transplants"—K. W. Cosgrove, M. D., Little Rock.

"Newer Concepts in Treatment of Arteriosclerotic Obliterative Disease"—Peter O. Thomas, M. D., Little Rock.

"Ectopic Pregnancies"—Melvin McCaskill, M. D., Little Rock.

Wednesday, April 19th, 1:30 P. M.

HOUSE OF DELEGATES.

DENT SECTION PROGRAM

Auditorium, St. Edwards Nurses Residence

Tuesday, April 18th, 10:00 A. M.

Chairman's Address—C. G. Hinkle, M. D., Batesville.

"Report on a Clinical Pathological Case"—E. C. Moulton, Jr., M. D., Fort Smith.

"Manifest Refractions"—A. N. Lemoine, Jr., M. D., Kansas City, Kansas.

12:30 P. M.

Luncheon with Round-Table Discussion.

Tuesday, April 18th, 2:00 P. M.

"Serous Otitis Media"—Paul L. Mahoney, M. D., Little Rock.

"Laryngeal Tumors, Classification and Diagnosis"—James B. Costen, M. D., St. Louis, Missouri.

"Vitamin A in Tinnitus"—Louis K. Hundley, M. D., Pine Bluff.

PRELIMINARY PROGRAM

**TWENTY-SIXTH ANNUAL SESSION
WOMAN'S AUXILIARY TO THE ARKANSAS
MEDICAL SOCIETY**

**Hotel Ward
Fort Smith, Arkansas
April 17 and 18, 1950**

OFFICERS

PRESIDENT—Mrs. Louis K. Hundley, Pine Bluff.

PRESIDENT-ELECT—Mrs. Warren S. Riley, El Dorado.

FIRST VICE-PRESIDENT—Mrs. P. W. Lutterloh, Jonesboro.

SECOND VICE-PRESIDENT—Mrs. John Price, Monticello.

THIRD VICE-PRESIDENT—Mrs. J. G. Martindale, Hope.

FOURTH VICE-PRESIDENT—Mrs. J. K. Donaldson, Little Rock.

RECORDING SECRETARY—Mrs. Howard S. Stern, Pine Bluff.

CORRESPONDING SECRETARY—Mrs. James T. Rhyne, Pine Bluff.

TREASURER—Mrs. V. T. Webb, Little Rock.

PUBLICITY SECRETARY—Mrs. Joe Verser, Harrisburg.

HISTORIAN—Mrs. C. W. Garrison, Little Rock.

PARLIAMENTARIAN—Mrs. Martin C. Hawkins, Searcy.

POET LAUREATE—Mrs. George B. Fletcher, Hot Springs.

COUNCILLORS

Mrs. A. C. Shipp, Little Rock.

Mrs. E. L. Thompson, Hot Springs.
 Mrs. Fred Hames, Pine Bluff.
 Mrs. W. J. Hunt, Warren.
 Mrs. Mason G. Lawson, Little Rock.

COMMITTEE CHAIRMEN

ORGANIZATION—Mrs. P. W. Lutterloh, Jonesboro.
 EDUCATION AND PUBLIC HEALTH—Mrs. John Price, Monticello.
 HYGEIA—Mrs. J. G. Martindale, Hope.
 PUBLIC RELATIONS—Mrs. J. K. Donaldson, Little Rock.
 PHYSICAL HEALTH EXAMINATIONS—Mrs. H. T. Smith, McGehee.
 MEMORIAL AND CHAPLAIN—Mrs. H. K. Wright, Hot Springs.
 LEGISLATION—Mrs. Charles R. Henry, Little Rock.
 ILSE F. OATES STUDENT LOAN FUND—Mrs. Charles E. Oates, Little Rock.
 MARTHA HARDING GANN MEMORIAL LOAN FUND—Mrs. C. W. Jones, Benton.
 DOCTOR'S DAY—Mrs. D. W. Dykstra, North Little Rock.
 ARCHIVES—Mrs. Calvin Churchill, Batesville.
 CONSTITUTION AND BY-LAWS—Mrs. E. D. McKnight, Brinkley.
 CANCER CONTROL—Mrs. W. R. Brooksher, Fort Smith.
 BIOGRAPHY—Mrs. Charles W. Dixon, Gould.
 POST-WAR PLANNING—Mrs. S. A. Thompson, Camden.
 EXHIBITS—Mrs. Gordon P. Oates, Little Rock.
 BULLETIN—Mrs. C. E. Kitchens, De Queen.
 ERLE CHAMBERS MEMORIAL LIBRARY FUND—Mrs. Mahlon D. Prickett, Little Rock.
 MEMBERS-AT-LARGE—Mrs. L. G. Fincher, El Dorado.
 NURSE RECRUITMENT—Mrs. Garland Murphy, Jr., El Dorado.
 PROGRAM—Mrs. Lamar McMillin, Little Rock.
 SPECIAL SPEAKERS BUREAU—Mrs. R. B. Robins, Camden.
 FINANCE—Mrs. Barton A. Rhinehart, Little Rock.
 COMMITTEE FOR THE EXTENSION OF MEDICAL CARE—Mrs. Mason G. Lawson, Little Rock.
 JANE TODD CRAWFORD MEMORIAL STUDENT LOAN FUND—Mrs. W. M. Lamb, Paragould.
 MEMBERSHIP—Mrs. Warren S. Riley, El Dorado.
 PUBLICITY—Mrs. Joe Verser, Harrisburg.
 ESSAY CONTEST—Mrs. W. J. Hunt, Warren.
 RESEARCH AND ROMANCE OF MEDICINE—Mrs. H. Clay Chenault, Hot Springs.

DELEGATES TO THE ARKANSAS LEGISLATIVE LEAGUE

Mrs. Mason G. Lawson, Little Rock.
 Mrs. Charles R. Henry, Little Rock.

COUNCIL WOMAN TO THE AUXILIARY TO THE SOUTHERN MEDICAL ASSOCIATION

Mrs. Louis K. Hundley, Pine Bluff.

COUNCIL WOMEN AND DISTRICTS

FIRST—Clay, Crittenden, Craighead, Greene, Lawrence, Mississippi, Poinsett, and Randolph counties: Mrs. Paul Stroud, Jonesboro.
 SECOND—Clebune, Fulton, Independence, Izard, Jackson, Sharp, Stone, and White counties: Mrs. Joel Monfort, Batesville.
 THIRD—Arkansas, Cross, Lee, Monroe, Phillips, Prairie, Saint Francis, and Woodruff counties: Mrs. Thomas Champion, Stuttgart.
 FOURTH—Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Jefferson, and Lincoln counties: Mrs. J. B. Holder, Monticello.
 FIFTH—Calhoun, Columbia, Dallas, Lafayette, Ouachita,

and Union counties: Mrs. Joe Rushton, Magnolia.
 SIXTH—Hempstead, Howard, Little River, Miller, Nevada, Pike, Polk and Sevier counties: Mrs. R. C. Dickinson, Horatio.

SEVENTH—Clark, Garland, Hot Spring, Montgomery, and Saline counties: Mrs. Joe Boydstone, Hot Springs.

EIGHTH—Conway, Faulkner, Grant, Lonoke, Perry, Pope, Pulaski, Van Buren, and Yell counties: Mrs. Gordon P. Oates, Little Rock.

NINTH—Baxter, Boone, Carroll, Marion, Newton, and Searcy counties: Mrs. Ross Fowler, Harrison.

TENTH—Benton, Crawford, Franklin, Johnson, Logan, Madison, Sebastian, Scott, and Washington counties: Mrs. Alfred Hathcock, Fayetteville.

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Dr. Louis K. Hundley, Pine Bluff, Chairman.
 Dr. Joe Verser, Harrisburg.
 Dr. Charles R. Henry, Little Rock.

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 BOWIE-MILLER—Mrs. A. A. Little, Texarkana.
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 GARLAND—Mrs. Leeman King, Hot Springs.
 GREENE-CLAY—Mrs. W. M. Lamb, Paragould.
 HEMPSTEAD—Mrs. J. G. Martindale, Hope.
 HOT SPRING—Mrs. C. F. Peters, Malvern.
 HOWARD-PIKE—Mrs. H. H. Holt, Nashville.
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 POPE-YELL—Mrs. Roy Millard, Russellville.
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 SEBASTIAN—Mrs. J. Kenneth Thompson, Fort Smith.
 SEVIER-POLK—Mrs. R. C. Dickinson, Horatio.
 SOUTHEAST ARKANSAS—Mrs. Bryan Barlow, Dermott.
 UNION—Mrs. Frank Thibault, El Dorado.
 WASHINGTON—Mrs. Alfred Hathcock, Fayetteville.

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CONVENTION CHAIRMAN—Mrs. Thomas P. Foltz.
 ENTERTAINMENT—Mrs. J. S. Southard, Chairman; Mrs. Charles T. Chamberlain, Mrs. Everett Foster, Mrs. V. N. Kennedy, Mrs. Everett Moulton.
 COURTESY—Mrs. I. F. Jones, Chairman; Mrs. Arthur F. Hoge, Mrs. S. J. Wolferman, Mrs. B. L. Ware, Mrs. Charles S. Holt, Mrs. J. E. Stevenson, Mrs. A. A. Blair.
 PUBLICITY—Mrs. Ben H. Pride, Chairman; Mrs. J. D. Olson, Mrs. Carl L. Wilson, Mrs. E. C. Moulton, Jr.
 TRANSPORTATION—Mrs. W. Loton Shippey, Chairman; Mrs. John Ben Stewart, Mrs. Ralph E. Crigler, Mrs. Walter G. Eberle, Mrs. W. F. Rose.
 TICKETS, REGISTRATION AND CREDENTIALS—Mrs. L. A. Whittaker, Chairman; Mrs. Ralph G. Kramer, Mrs. Art B. Martin, Mrs. S. Wright Hawkins, Mrs. W. F. Adams, Mrs. A. S. J. Clarke, Mrs. W. E. Knight, Mrs. Robert Thompson, Mrs. Marlin Hoge, Mrs. F. E.

Shearer, Mrs. Roy Shirmer, Mrs. S. P. Stubbs, Jr., Mrs. J. K. Thompson, Mrs. E. A. Mendelsohn.
 PAST PRESIDENTS' BREAKFAST—Mrs. W. R. Brooksher, Chairman.

PROGRAM

Monday, April 17, 1950

10:00 A. M.—Registration, Mezzanine Floor, Hotel Ward.
 11:00 A. M.—Pre-Convention Board Meeting, Silver Lounge, Hotel Ward.
 12:00 Noon—Luncheon for General Membership, Gold Room, Hotel Ward. (Cost, \$2.00. Reservations will be taken until 11:30 A. M.)
 Presiding—Mrs. Louis K. Hundley.
 Invocation—Mrs. L. T. Evans, Batesville.
 Address—Mrs. R. C. Haynes, President, Woman's Auxiliary to the Southern Medical Association, Marshall, Missouri.
 Address—Miss Mary McGinn, Director, Woman's Division, National Education Campaign of the American Medical Association, Chicago, Illinois.
 2:00 P. M.—Opening General Session, Gold Room, Hotel Ward.
 Presiding—Mrs. J. Kenneth Thompson, President, Woman's Auxiliary to the Sebastian County Medical Society.
 Address of Welcome—Mrs. A. S. J. Clarke, Fort Smith.
 Introduction of the State President—Mrs. Louis K. Hundley, Pine Bluff.
 Response to the Address of Welcome—Mrs. William Hibbitts, Texarkana.
 Introduction of Special Guests:
 Mrs. Arthur A. Herold, President-Elect, Woman's Auxiliary to the American Medical Association, Shreveport, Louisiana.
 Mrs. R. C. Haynes, President, Woman's Auxiliary to the Southern Medical Association.
 Miss Mary McGinn, Director, Woman's Division, National Education Campaign of the American Medical Association.
 Report of the Chairman, Woman's Auxiliary Advisory Committee, Arkansas Medical Society—Dr. Louis K. Hundley, Pine Bluff.
 Reports of the Officers.
 Reports of the Committee Chairmen.
 Report of the Sixth Annual Conference of the Woman's Auxiliary to the American Medical Association—Mrs. Warren S. Riley, El Dorado.
 Report of the Convention of the Woman's Auxiliary to the American Medical Association—Mrs. Mason G. Lawson, Little Rock.
 Report of the Meeting of the Woman's Auxiliary to the Southern Medical Association—Mrs. C. A. Archer, De Queen.
 Announcement of Special Committees—Mrs. J. Kenneth Thompson, Fort Smith.
 Report of the Registration and Credentials Committee—Mrs. L. A. Whittaker, Fort Smith.
 Report of the Entertainment Committee—Mrs. J. S. Southard, Fort Smith.
 Mrs. R. C. Dickinson, Horatio—Timekeeper
 6:30 to 9:30 P. M.—Open Houses. Transportation will be furnished at the side entrances of the

hotels.

Dr. and Mrs. J. Kenneth Thompson—Cooper Clinic, North 12th and A Sts.
 Dr. and Mrs. Fred H. Krock—Holt-Krock Clinic, Hardscrabble Country Club.
 Dr. and Mrs. A. S. Koenig—2122 South W Street.

Dr. and Mrs. Thomas P. Foltz—2712 Lela Avenue.

Tuesday, April 18, 1950

8:00 A. M.—Past Presidents' Breakfast, Silver Lounge, Hotel Ward.
 Chairman—Mrs. W. R. Brooksher, Fort Smith.
 9:30 A. M.—General Session, Gold Room, Hotel Ward.
 Presiding—Mrs. Louis K. Hundley, Pine Bluff.
 Invocation—Mrs. C. E. Kitchens, De Queen.
 Reading of the Minutes.
 Address—Dr. Euclid M. Smith, President, Arkansas Medical Society, Hot Springs.
 Reports of the Presidents of County Auxiliaries.
 Election of Delegates to the Convention of the Woman's Auxiliary to the American Medical Association.
 Report of the Registration and Credentials Committee—Mrs. L. A. Whittaker, Fort Smith.
 Election of Officers.
 Announcement of the Entertainment Committee—Mrs. J. S. Southard, Fort Smith.
 Mrs. James T. Rhyne, Pine Bluff—Timekeeper
 11:40 A. M.—Memorial Session, Main Dining Room, Hotel Goldman. Transportation will be furnished at the side entrance of the hotel. (Joint session with the Arkansas Medical Society.)
 1:00 P. M.—Luncheon, Hardscrabble Country Club. Transportation will be furnished at the side entrance of the hotel. (Cost, \$2.50. Reservations will be taken until 10:00 A. M.)
 Toastmistress—Mrs. J. Kenneth Thompson, Fort Smith.
 Introduction of Past Presidents.
 Introduction of State Officers.
 Introduction of wives of Officers of Arkansas Medical Society.
 Introduction of the Poet Laureate—Mrs. George B. Fletcher, Hot Springs.
 Unfinished business.
 Report of the Committee on Courtesy Resolutions.
 Address—Mrs. Arthur A. Herold, President-Elect, Woman's Auxiliary to the American Medical Association, Shreveport, Louisiana.
 Installation of the 1950-1951 Officers—Mrs. Mason G. Lawson.
 Presentation of the Gavel—Mrs. Louis K. Hundley.
 Address of the Incoming President—Mrs. Warren S. Riley.
 Post-Convention Board Meeting—Card Room, Hardscrabble Country Club. Presiding—Mrs. Warren S. Riley.
 7:00 P. M.—Buffet Supper and Dance, Dining Room, Hotel Goldman, given by the Sebastian County Medical Society.
Wednesday, April 19, 1950
 9:30 A. M.—School of Instruction, Silver Lounge, Hotel Ward. For State Officers, Members of the Board and County Presidents.



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REPORT OF THE EXECUTIVE SECRETARY

MR. SID WRIGHTSMAN, JR.

Because of the National Administration's increased effort to pass legislation tending to be along lines of compulsory health measures, combined with a growing public interest in stemming welfare statism—an interest enhanced by publication of the Hoover Commission Report early last year—the executive secretary throughout 1949 devoted considerable time to keeping Society members informed on legislative trends affecting them, both as citizens and physicians.

This, in the main, was accomplished by the frequent issuing of special news bulletins on the advice of Dr. W. R. Brooksher, Secretary, and Dr. Charles R. Henry, Chairman of the Committee for the Extension of Medical Care.

To carry on the education campaign in the state as envisioned by the Committee for the Extension of Medical Care, the Council, early in 1949, authorized the employment by the executive secretary of a full-time stenographic assistant and approved purchase of suitable mimeograph equipment, an addressing machine and other necessary office paraphernalia for his office.

In addition, his office cooperated in furthering state campaign activities by (1) serving as the major point of distribution of campaign material furnished by Whitaker & Baxter, public relations counsel for the American Medical Association and (2) state collection agency for the 1949 AMA voluntary assessment on members and (3) cooperating with officers of the Woman's Auxiliary in their various activities requiring the distribution of mimeographed material to the Auxiliary membership.

On December 31, 1949, the Society had a total of 1,220 members in-good-standing, having remitted 1949 State dues.

In the collection of the 1949 AMA voluntary assessments, this Society stood twentieth on the list of fifty-three constituent associations comprising the American Medical Association. The sum collected represented payment of the assessment by approximately 73 per cent of the Society membership.

The executive secretary is convinced that experiences learned during the past year will prove invaluable to him in his work for the Society during 1950, an election year which, even now, has every indication of being a decisive period in the Administration's campaign for compulsory health measures.

For their continuous cooperation and innumerable courtesies shown him throughout 1949, the executive secretary expresses profound gratitude both to officers and members of the Arkansas Medical Society.

AUXILIARY NEWS

Mrs. W. F. Shepherd, 705 W. Washington, Jonesboro, succeeds Mrs. G. M. Kinzer as president of the Craighead-Poinsett County Auxiliary.

Mrs. Pierre Redman of Mena was recently elected president of Sevier-Polk County Medical Auxiliary. She succeeds Mrs. R. C. Dickinson of Horatio.

Mrs. Louis K. Hundley, State President to the Woman's Auxiliary, visited Arkansas County Medical Auxiliary on January 17th, Craighead-Poinsett County Auxiliary on February 1st, and

Clay-Greene County Auxiliary on February 2nd.

The Washington County Auxiliary met January 20th with Mrs. Fred Ogden. Ten members were present. The Auxiliary members are making a study of the Hoover plan, also national bills pertaining to health insurance. Telegrams from Auxiliary members were sent to Washington concerning bills pending in Congress.

We received "Thank You" letters from families overseas to whom we sent CARE packages.

Mrs. P. L. Hathcock, Sec'y.

The Sebastian County Medical Auxiliary met for luncheon in the McCortney House on January 9th. Mrs. Kenneth Thompson and Mrs. Ben H. Pride were hostesses.

Mrs. Louis K. Hundley, State Auxiliary President, who was our guest for the evening, gave a very interesting talk on Socialized Medicine.

During the business meeting final plans were discussed for the State convention.

Mrs. Ben H. Pride

The Auxiliary to the Craighead-Poinsett County Medical Society was honored to have Mrs. Louis K. Hundley, State President, at the regular monthly meeting at the Jonesboro Country Club on February 1, 1950. Following dinner with the Doctors, Mrs. Hundley gave a most interesting and timely talk to the group concerning proposed legislation for compulsory health insurance, after which the ladies held a short business session. Mrs. Hundley talked informally with the ladies concerning the work of the Auxiliary. Several ladies agreed to be responsible for the placing of literature in various places of business for distribution to the public.

Mrs. W. F. Shepherd, Pres.

Mrs. M. O. Peeler, Sec'y.

The Garland County Medical Auxiliary met January 16th at the home of Mrs. Charles H. Lutterloh, with Mrs. John Dodson, Mrs. James W. Leatherman and Mrs. H. King Wade, Sr., as co-hostesses.

Mrs. Leeman King, President, presided over a short business meeting and introduced Mr. J. W. Slates, Executive Secretary for Arkansas Division of Cancer Control, who explained the program for cancer education.

The twenty-five members present were served lovely refreshments by the hostesses.

The next meeting will be a luncheon meeting at the Arlington Hotel with Col. Ralph Patterson, of the Army and Navy Hospital, as guest speaker.

Mrs. L. E. Reed

The Pope-Yell County Medical Auxiliary met in the home of the president, Mrs. Roy S. Millard, for their January meeting. Plans for the future months were discussed in the regular business meeting.

Mrs. William O. Young,
Publicity Chairman.

Mrs. Louis K. Hundley spoke to the Sebastian County Medical Auxiliary on January 9th. Final plans were made for the state meeting to be held in Fort Smith on April 17th, 18th and 19th.

The Howard-Pike County Medical Auxiliary held their meeting January 12th at the Howard County Memorial Hospital. The Auxiliary members were guests at a dinner given for doctors of Howard-Pike counties by the dietitian at the hospital. A delightful meal was served. During the dinner, honor was given those doctors who had served the profession 40 years or more and a tribute was paid in memory of the late doctors: E. Van Dildy, W. M. Gibson, D. A. Hutchinson, J. M. Holt and J. S. Hopkins.

After dinner the Auxiliary held its regular meeting. During the business meeting plans were discussed for future activity—particularly for Doctor's Day. An hour of social fellowship was enjoyed by the eleven members present.

Mrs. J. S. Hopkins, Sec'y.

BOOK REVIEW

The Physiology of Heat Regulation and the Science of Clothing: Edited by L. H. Newburgh, M.D., Professor of Clinical Investigation, The Medical School, University of Michigan. Pp. 450 with illustrations. W. B. Saunders Company, Philadelphia, Pa.

Fifteen investigators interested in the physiology of temperature regulation are contributors to this volume. The book is divided into two main parts. The first is concerned with human response to the climatic environment. The climatic conditions of the various parts of the earth are portrayed. The physiological mechanisms by which man has been able to adapt himself to extremes of climate are explained in the light of present knowledge. There is a rather complete exposition of the various physiological mechanisms concerned with temperature control. In completeness of knowledge is expressed on some problems such as of the adjustment mechanisms by which the Yohgans of Tierra del Fuego and the Australian aborigines are able to sleep naked on the cold ground. The second part of the book gives consideration of clothing as a thermal barrier. Scientific evidence is given for the choice of suitable clothing for various climatic conditions. The material of the book is presented in a way that makes it interesting and valuable for layman or specialist.

Textbook of Physiology: (Originally by William H. Howell,

M.D.) Edited by John F. Fulton, M.D., Sterling Professor of Physiology, Yale University School of Medicine, New Haven, Connecticut. 16th Edition Cloth. Price \$10. Pp. 1,213, with illustrations. W. B. Saunders, Philadelphia, Pa. 1949.

In this new revision, Dr. Fulton has continued the meritorious presentation that has characterized this text since Dr. Howell's first edition. The discussions have been brought up to date. In many chapters some of the early work of 1949 is included. The subject matter is arranged in logical sequence for presentation to medical students. The introductory chapter gives a fitting historical background to the subject. The first part of the book considers thoroughly the physiology of nerve and muscle, a subject that is neglected in most of the other standard texts in use at the present time. The subsequent sections on the central and peripheral nervous systems continue to be the outstanding feature of the text. The chapters on circulation and respiration are well organized and adequate for the major needs of student or practitioner. The chapters on kidney, metabolism and endocrines are less extensive than desirable but give the pertinent essential facts.

Geriatric Medicine—The Care of the Aging and the Aged: Edited by Edward J. Stieglitz, M.S., M.D., F.A.C.P., Attending Internist, Suburban Hospital, Bethesda, Maryland; Doctor's Hospital, Washington, D. C. New, 2nd edition. 773 pages, with 180 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price \$12.00.

This volume, in its second edition, is the product of distinguished authorities in their respective fields. All physicians who see older patients, and their number is increasing, will find this book of value. Careful study of the text will be of profit to the physician who, too, becomes older in due course of events.

Diseases of the Foot: By Emil D. W. Hauser, M.S., M.D., Associate Professor of Bone and Joint Surgery, Northwestern University Medical School. New, Second Edition. 415 pages with 195 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price \$7.00.

The second edition of Dr. Hauser's complete and practical book is enhanced by a change in its physical makeup, resulting in a handsome and easily readable volume. The entire book has been further benefited by the addition of several excellent photographs and illustrations, and also by the deletion of a considerable portion of academic illustrations and comment, amounting to a reduction of 57 pages.

The general physician and surgeon, as well as the orthopedist, would do well to have ready reference to the subjects covered by this volume. Many patients have been forced to seek improper treatment from "foot doctors" because of the lack of the general physician's knowledge of such disorders. The discussions and methods, although strongly colored by the author's experience, hold an amazing amount of helpful information, and his insistence upon the re-establishment of normal foot function and gait will help the physician to guide the patient away from commercial appliances, which too often cripple the foot further. The corrective shoe alterations are explained so thoroughly that they may be applied in the smallest community. It is a type of book which will result in benefit to both the doctor and the patient.

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No. 11

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The JOURNAL

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PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. XLVI

FORT SMITH, ARKANSAS, APRIL, 1950

No. 11

RUPTURE OF THE PREGNANT UTERUS *

HUBERT L. ALLEN, M.D.
Alton, Illinois

Rupture of the pregnant uterus creates an obstetrical emergency of the first magnitude. Its management must be well organized, prompt and efficient to prevent death of the mother; the outlook for the baby is always dark. The gravid uterus may rupture at any time during gestation, either as a result of external trauma, intrinsic pathological change in the uterine wall, mechanical obstruction of labor, or any combination of these factors. The treatment is preventive, where possible; the gravida who obtains good antenatal care is much less likely to rupture than the one who has not had medical advice. Spontaneous ruptures which give no warning do occur, but, as Asa B. Davis (1) once said: "The time to treat rupture of the uterus is before it occurs. In the last analysis it means better, more conscientious and systematic care during pregnancy, labor and the post-partum state."

Incidence

The highest incidence to be found in the literature is that reported by Whitacre and Fang (2) from the Peiping College Hospital. In the seven year period from 1934 to 1941, there was one rupture in every 95 deliveries. However, only one-sixth of these cases were clinic patients; the balance had been admitted as dire emergencies, having had no previous medical attention. Other writers report the incidence as one in several thousand deliveries, but the most commonly accepted figure is one in about 1500.

Dugger (3) surveyed the maternal mortality records of Philadelphia County for a ten year period and found 105 ruptures in 318,103 live births and still births, an incidence of one in 3,029 births. The frequency of rupture before the onset of labor was 25.8%; during labor 32.4%; at delivery 40.9%. It is probable that many cases of rupture are not diagnosed. New-

berger, of the Maternal and Infant Welfare Division of the Illinois Department of Public Health, says that there were eighty-one maternal deaths in downstate Illinois in 1948, among which were two proven cases of rupture of the uterus. The word "proven" is significant. It is likely that some unrecognized ruptures lead to fatal-

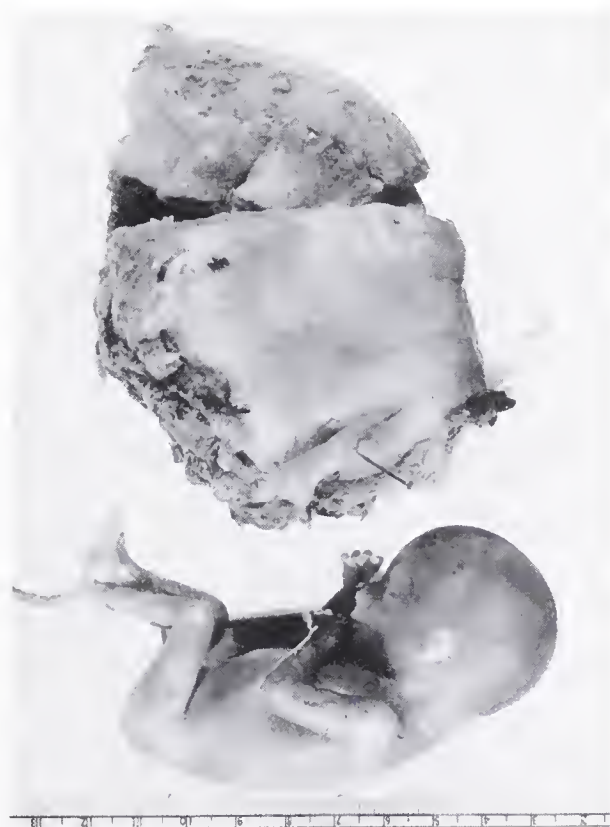


FIGURE 1—CASE 2

View of amputated uterus showing intact left tube.

ities which are broadly signed out as "post-partum hemorrhage and shock," without autopsy examination to establish the proper diagnosis.

Etiology

In general it may be said that the cause of rupture of the pregnant uterus may be either intrinsic or extrinsic to the uterine muscle, while it may occur either spontaneously or as a result of trauma. The principle etiological factors may be summarized as follows:

I. Spontaneous

*Read before the Seventy-Third Annual Session, Arkansas Medical Society, Little Rock, April 14, 1949.

- A. Uterine wall deficiencies due to intrinsic pathology
 - 1. Anomalies of the uterus (didelphys, bicornis, unicornis, etc.)
 - 2. Degenerative changes in uterine muscle (multiparity?)
 - 3. Abnormal invasion of trophoblast (invasion mole, placenta accreta, chorio-carcinoma)
 - 4. Intramural Myomata
 - 5. Co-existing adenomyosis or adenocarcinoma
 - 6. Hemorrhagic infiltration of myometrium (abruptio placentae)

- B. Weakening of uterus due to overdistention
 - 1. Polyhydramnios
 - 2. Multiple pregnancy

II. Traumatic

- A. Uterine weakness due to previous operation
 - 1. Caesarian section, especially the classical type
 - 2. Myomectomy
 - 3. Tubal resection with excision of interstitial portion of tube.
 - 4. Previous manual removal of placenta
 - 5. Curettement for infected abortion
 - 6. Lower uterine segment operations (Spinelli, vaginal Caesarian section, vaginal hysterotomy)

- B. Conditions producing obstruction of labor
 - 1. Previous surgery on the genital tract (cervical amputation, ventrofixation of uterus, interposition of uterus, extensive pelvic floor repair)
 - 2. Contracted pelvis
 - 3. Large baby, monstrosity or fetal tumor
 - 4. Pelvic tumor obstructing birth canal
 - 5. Cervical dystocia
 - 6. Prolonged second stage with ruptured membranes
 - 7. Pathological retraction ring
 - 8. Deflexion attitude of fetus
 - 9. Transverse or oblique presentation
 - 10. Cervical or vaginal stenosis
 - 11. Vaginal or cervical septa or bands

- C. Administration of ergot or pituitary extract during labor

- D. Obstetrical manipulations
 - 1. Excessive pressure on uterine fundus
 - 2. Version and extraction
 - 3. Application of forceps through incompletely dilated and retracted cervix

- 4. Dührssen's incisions of the cervix (extension of)
- 5. Manual removal of the placenta
- 6. Manual dilatation of the cervix
- 7. Use of hydrostatic bag
- 8. Embryotomy

- E. External violence (falls, kicks, penetrating and perforating wounds, etc.)

Ruptures do occur in intact uteri, where there is no history of operation or infection. As pointed out by Davis (1), Mahfouz (4), and others, there is considerable individual variation in the



FIGURE 2—CASE 2

Uterus seen from above left, showing rupture site.

tendency to laceration of the birth canal: some patients seem to lack tissue resistance which causes them to tear after an easy labor, while others will tolerate very considerable distention and remain intact. In general, the older age group seems to be more vulnerable in this respect. Spontaneous rupture is rare, for it is usually possible to assign a direct cause. Bloom (5) feels that the term "spontaneous" should be reserved for the rupture resulting from intrinsic pathology of the uterine muscle existing unknown to the obstetrician. Two of our cases are examples of this type:

Case No. 1; Mrs. L. W.; age 28, gravida ii, para i. February, 1941.

This patient had one previous, normal pregnancy and delivery in 1939.

She was hospitalized in January, 1941, with a diagnosis of threatened abortion at 20 weeks' gestation. Symptoms were abdominal cramping and intermittent, moderate vaginal bleeding. Treatment consisted of bed rest and administration of progesterone. She was discharged after 11 days and readmitted 19 days later with the same symptoms, the vaginal bleeding being more profuse.

At this time the patient was seen in consultation. She was markedly anemic and there was moderate bright red vaginal bleeding. The lower abdomen was occupied by a symmetrical, firm, tender mass arising from the pelvis in the mid-line to the umbilicus. Fetal heart tones were not audible. Vaginal examination revealed the uterus, about three times enlarged, displaced upward and forward by a large, fixed, indurated mass which filled the pelvis. On culdesac aspiration, no blood was recovered. After multiple transfusions, laparotomy was performed. The uterus was riding up and toward the right side on a left broad ligament hematoma. A fetus of approximately 16 weeks' development lay free in the pelvic cavity, having been extruded through the posterior leaf of the broad ligament. It was badly macerated and still attached by the cord to the degenerated placenta which filled the uterine cavity and protruded through a rent in the left lateral wall. Supracervical hysterectomy, left salpingo-oophorectomy and repair of the left broad ligament were performed. The patient made an uneventful recovery and is well at the present time.

Examination of the uterus revealed pathological invasion of the posterior wall by the trophoblast, so that its thickness varied from 3 to 10 mm. Microscopic examination revealed a fairly typical picture of placenta accreta, characterized by absence of well developed decidua and attachment of chorionic villi in the musculature. The myometrium in this area was necrotic and the sections stained poorly.

Case No. 2; Mrs. L. M.; age 40; gravida vii, para v March 6, 1949.

This is another case of spontaneous rupture which occurred quite opportunely while this paper was in preparation. It is sufficiently interesting to merit detailed presentation.

This patient had normal, full-term pregnancies and deliveries in 1928, 1931, 1936, 1943 and 1946. The last two babies were delivered by my associate and me. There were no third stage complications and involution was complete at post-partum examination. Following the birth

of her last baby, there was some alteration in menstruation, the flow being generally heavier than formerly.

In October, 1948, she had an early spontaneous abortion, without sequelae or curettage.

She was next seen on the morning of March 6, 1949, when she was admitted to St. Joseph's Hospital in profound shock, pale, sweating and dyspnoeic. She had not menstruated since December, but had not yet registered for prenatal care. The day before admission she had experienced moderate lower abdominal cramping pain, but there was no bleeding and the discomfort was not severe. At bed time that night, she developed more severe lower abdominal pain which was partly relieved by the use of a heating pad. She succeeded in going to sleep but was awakened about 4 A. M. by an intense, knife-like pain in the lower mid-abdomen and

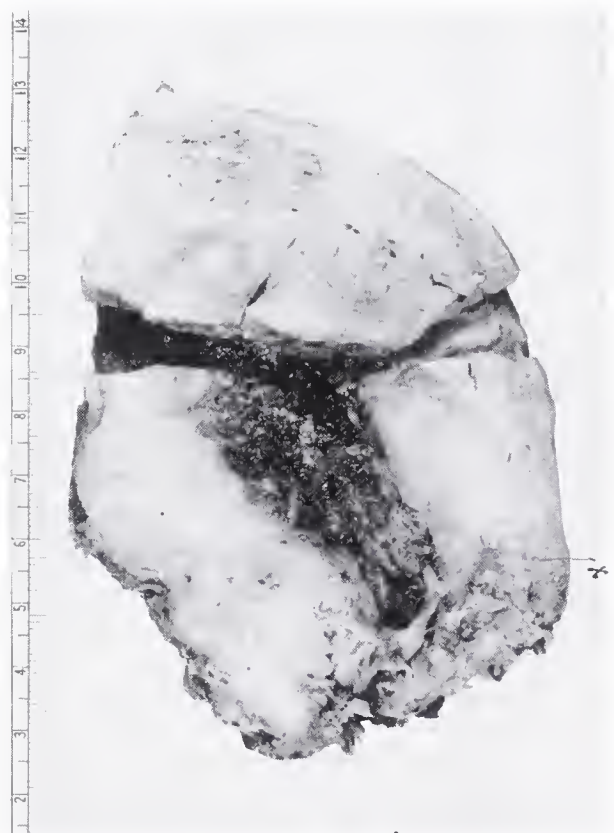


FIGURE 3—CASE 2
Coronal section of uterus showing rupture. "X" indicates abnormal trophoblastic invasion of uterine wall.

pain in the right shoulder. A neighbor called about 8 A. M. and described such a graphic picture of shock that there was time to secure the patient's blood type and Rh factor determination from the office record and to alert the blood bank and operating room before the patient arrived at the hospital. On admission, she was in a state of collapse, with a rapid, barely perceptible pulse. Hasty examination revealed

distention and rigidity of the lower abdomen with evidence of free intraperitoneal fluid. She was taken immediately to surgery where massive transfusion was commenced. As soon as the blood was running well, the abdomen was opened, revealing a large quantity of fluid and clotted blood under some pressure. The source of the bleeding was the left portion of the uterine fundus. Bleeding was quickly controlled by clamping the blood supply and the pelvis carefully explored. Both tubes and ovaries were normal and intact. There was a circular defect in the left posterolateral aspect of the uterine fundus measuring about 5 cm. in diameter. The fetus and placenta, had been expelled through this opening. The small placenta, measuring about 8 cm. in diameter, was found free in the upper left abdomen. The fetus was recovered from the culdesac. A supracervical hysterectomy was performed and the abdomen closed without drainage. The patient made an uneventful recovery and was discharged on the 11th postoperative day.

Examination of the amputated uterus revealed that the interstitial portion of the tube was not involved. Rupture occurred in the left posterolateral aspect of the fundus through an area weakened by pathological invasion of the trophoblast. Figure 3 shows the marked thinning of the wall in this region. Microscopically, the picture is one of placenta accreta, which implantation of the chronic villi directly into the musculature without the normal intervention of a well developed decidua.

Undoubtedly the most frequent cause of rupture of the pregnant uterus is previous Caesarian section and this is a problem which we as practitioners are frequently called upon to manage.

The following case is illustrative:

Case No. 3; Mrs. E. M.; gravida ii, para i. July 29, 1948.

This was a 21-year-old para i who had been delivered by classical Caesarian section 2 years before. She was admitted to St. Joseph's Hospital at term, after 4 hours of labor at home, and was seen by her doctor 45 minutes later. He noted the following facts: hard, rhythmic uterine contractions, transverse presentation confirmed by X-ray, and absence of fetal heart tones. The general condition of the patient was satisfactory. Consultation was called, but the consultant was completing a delivery at another hospital. Telephone instructions were given to take the patient to the operating room, start transfusion, and prepare for immediate laparotomy. When the consultant arrived 20 minutes later, the patient had begun to develop signs

of shock which quickly became profound. With blood being pumped under pressure into two extremities, the abdomen was opened, revealing the following situation: the placenta and dead baby still surrounded by its intact membranes were lying free in the upper left abdomen. The uterus had ruptured along the old incision line with such explosive force that it had completely inverted. The tear had extended at an angle of 90 degrees to the left, avulsing the bladder peritoneum without injury to that organ and lacerating the left broad ligament. Bleeding of course, was furious, but was easily controlled by clamping the left uterine and ovarian arteries, replacing the inverted uterus and performing a supracervical hysterectomy. The abdomen was closed without drainage, and the patient made an uneventful, afebrile recovery.

Ranking next in importance is external trauma. Many cases of rupture following falls, automobile accidents, kicks and wounds have been reported. The following rather unusual case is an example of this category:

Case No. 4; Miss E. W.; gravida ii, para 1. September 1, 1946.

This 18-year-old girl, illegitimately pregnant for the second time, took direct action against her unwelcome baby during the eighth month of pregnancy. About 2 P. M. on the day of admission to the hospital, she pressed the muzzle of a .22 caliber rifle to the side of her abdomen where fetal movement was most annoying, and managed to push the trigger. Four hours later, she was admitted to St. Joseph's Hospital, complaining of generalized abdominal pain, but in generally good condition. Consultation was called at 10 P. M., some 8 hours after the shooting. At that time, the pregnant uterus was 28 cm. in height, tender and broad-like in consistency. The fetal heart tones were faintly audible. Rectal examination revealed a firm, undilated cervix. The head was not engaged. Abdominal findings were similar to those found in abruptio placentae.

Laparotomy was performed at about 11 P. M. The uterus was tense, presenting two small symmetrical jagged wounds on either side of the midline. Surrounding the wounds were areas of hemorrhagic infiltration, approximately 6 cm. in diameter. A classical Caesarian section was performed and an immature female infant delivered. It cried well and its color was excellent, but it had sustained a through and through gun-shot wound of the abdomen. The baby was turned over to a pediatrician and seen by a general surgeon in consultation. It was decided not to explore the baby and when it died of its

wounds 12 hours later, it was found that it had suffered extensive injuries of the bowel and left kidney. The uterus did not contract well and there was considerable bleeding around the wounds. A rather high supracervical hysterectomy was performed and the abdominal contents thoroughly explored. No further damage was found and recovery was uneventful.

It might be added that the county attorney, not knowing whether to classify this case as attempted suicide or murder, dropped it without action.

These traumatic cases are rare as compared to the ruptures resulting from well-meant obstetrical procedures. Version and extraction and improper use of oxytocic drugs are the chief offenders in this category. Innumerable case reports are concerned with their inherent dangers. As early as 1904, the dangers of ante-partum administration of pituitary extract were pointed out, and yet its use still causes numerous deaths. For example, in 1946, Dindia and Turcotte (6) reported five cases of rupture of the uterus occurring within 20 months in several Detroit hospitals. Three mothers and three babies died. Four of the five ruptures were said to be the result of improper administration of pituitary extract.

Internal podalic version and extraction is an operation which has declined in popularity as the rate of Caesarian section has increased. It is still one of the prime causes of uterine rupture. Most writers place it second, after classical Caesarian section.

Gordon and Rosenthal (7) quote Bingham as reporting that rupture of the uterus was a frequent cause of death in the State of New Jersey, and that one-half of these cases resulted from the performance of podalic version. In Dugger's 105 cases of rupture, internal version had been done in 30. Only two of the patients recovered. Ruptures following version accounted for 40% of maternal deaths and 34.8% of fetal deaths in his series. Version for neglected shoulder presentation is especially apt to produce rupture. One has only to consider the marked distortion of normal anatomy in neglected shoulder presentation to realize how greatly distended is the lower uterine segment in this condition and how little force is required to rupture it. One of our cases is illustrative of this:

Case No. 5; Mrs. B. L.; age 31; gravida iv, para iii. June 5, 1947.

This patient was seen in consultation at St. Joseph's Hospital when in hard second stage labor with a right scapulo-anterior presentation.

The membranes were said to have ruptured 5 days before and she had been in labor 4½ hours. Fetal heart tones had been audible several times during the morning and 30 minutes before she was seen in consultation, but could not be heard at that time. The blood pressure was normal, but the pulse was rapid, and the temperature elevated to 100.6 degrees. We had, then, an impacted shoulder presentation, an intrapartum, intra-uterine infection, full dilatation and retraction of the cervix with overstretching of the lower uterine segment, and a baby which was

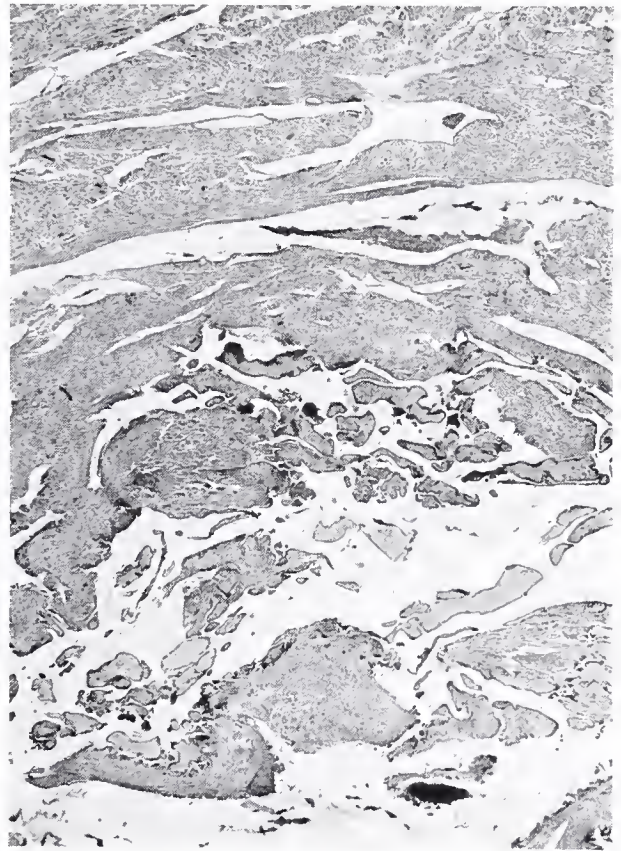


FIGURE 4—CASE 2

Implantation of chorionic villi directly into musculature.

probably dead, but possibly still alive. It was felt that there were three choices: embryotomy, version and extraction, or Caesarian hysterectomy. With full knowledge of the potent contraindications, the following procedure was carried out: The patient was deeply anesthetized with drop ether. As gently as possible, the presenting part was disengaged, and the head displaced upward out of the left iliac fossa. This was accomplished so easily that it was felt that uterine rupture might already have occurred. The baby was extracted dead-born. Because of likelihood of rupture, the placenta was removed and the uterine cavity explored. A sizable rent was found in the left side of the uterus. Bleeding was moderately profuse, but transfusion was

in progress. Three sponge forceps were inserted through the uterine tear and clamped to what was hoped to be the uterine pedicle. The defect was then packed and the patient taken to the operating room. Transfusion was continuous through two extremities. With the abdomen opened, it was found that the sponge forceps were controlling hemorrhage remarkably well. These and the pack were removed from below and a rapid supracervical hysterectomy performed. The abdomen was closed after drainage through stab wounds in the flanks. During the entire procedure, the blood pressure never faltered. Postoperatively the patient was maintained at high levels of sulfonamides and antibiotics. The highest postoperative temperature was 99.2 degrees. She was discharged in good condition on the twelfth postoperative day and never returned for follow-up examinations.

It is perfectly possible for a woman to sustain a severe cervical laceration or incomplete lower segment tear during labor or delivery, with very little evidence of the accident having occurred. All one needs to do to prove this is to adopt, as a routine, the practice of examining every cervix after delivery of the placenta, grasping both lips with sponge forceps and bringing them down for careful inspection. Such a patient is particularly vulnerable to rupture in subsequent pregnancy, especially if these silent lacerations are not repaired. This point has been emphasized by Bloom (5), Beacham and Varino (8) and others. It doubtless explains to some extent the much greater incidence of uterine rupture in multiparas than primiparas.

Classification

Ruptures of the pregnant uterus may be classified as complete or incomplete, depending upon whether or not the rupture extends into the peritoneal cavity. Thus, a lower segment rupture into the broad ligament would produce a hematoma in that structure, and the rupture would be classed as an incomplete one unless the broad ligament should itself rupture, spilling the blood into the peritoneal cavity.

Signs and Symptoms

One of the primary symptoms of impending rupture is pain. This is noted during contractions and between them, and the pain is usually most severe in the weakened area. Threatened rupture is always to be suspected in any case of prolonged labor, where the contractions are becoming progressively more severe and prolonged, with very little relaxation between them. The pulse may be elevated, and there is marked tenderness over the entire uterus, but especially

over the lower uterine segment. The round ligaments may become tense, tender and palpable through the abdominal wall. The so-called contraction ring of Bandl may appear as a transverse or oblique indentation across the abdomen, somewhat resembling a distended bladder. At this stage, it is easy to confuse the findings with those of abruptio placentae. When actual rupture occurs, there is usually sudden, sharp pain, and the patient may experience a sensation as of something "tearing loose inside." Shoulder and chest pain may be noted. Rhythmic contractions cease, the presenting part may recede, external bleeding may occur. Various degrees of shock supervene, and the contour of the abdomen is greatly altered, especially if the fetus has been expelled from the uterus.

Sometimes, evidence of impending rupture is misleading, as the following case shows:

Case No. 6; Mrs. R. L.; age 39; gravida iii, para i. February 18, 1949.

This patient was delivered by low cervical transverse Caesarian section in 1945 because of placenta praevia near term. Recovery was uncomplicated and afebrile, and the abdominal incision healed per primam. In 1946 she again became pregnant, but spontaneously aborted at about 12 weeks. There were no complications and curettage was not performed. She returned in July, 1948, with her third pregnancy. The pelvic measurements were adequate. Several times during the antenatal course, the patient complained of pain in the lower abdomen, intermittent in character.

She was at term on dates February 24, 1949, but contractions began on the 18th. On admission to St. Joseph's Hospital, the contractions were mild and irregular, the membranes intact and there was no bloody vaginal discharge. By 5 P. M., contractions were occurring every 5 minutes, lasting about 30 seconds and were of only fair intensity. Vaginal examination revealed a soft cervix, 1.5 cm. in length and about 1.5 cm. dilated. The vertex presented; the head was not engaged. The patient complained inordinately of the rather mild contractions, and there was tenderness over the lower uterine segment even on gentle palpation. She stated that she felt as if "something were pulling." Since a moderately long labor could be anticipated, further trial was not made, and another low cervical transverse Caesarian section was performed, with delivery of a normal infant. There were no adhesions, and the bladder peritoneum was easily separated. A careful inspection of the previous operative site was made

both before opening the uterus and after it had been emptied. The old scar was not identifiable, and there was no area of unusual thinning. Recovery was uncomplicated.

Rupture may occur during labor or delivery without being recognized. The following patient, a doctor's wife, is an example:

Case No. 7; Mrs. E. H.; gravida iii, para iii; August 2, 1946. Age 29.

This is a healthy young woman whose pelvic measurements are larger than average. In 1941 she delivered a 7-lb. 14-oz. baby by outlet forceps and episiotomy, after a long, tedious labor ascribed to cervical dystocia.

In February, 1943, she delivered a 10-lb. female by perineal forceps and episiotomy following a five hour labor. After delivery, according to the record obtained from the hospital, she complained of severe right lower quadrant abdominal pain, and was markedly anemic. She was transfused repeatedly without much improvement in the blood count. Examination 11 days post-partum revealed an involuting uterus, displaced to the left by a boggy mass filling the right side of the pelvis. This was drained vaginally and the mass consisted of about 600 cc. of blood and clots. Recovery was progressive thereafter.

In 1946 she was again pregnant. She was delivered by Caesarian section of a 6-lb. 6-oz. male infant 3 weeks before the calculated due date, because of the history of her second delivery. Examination of the uterus disclosed a large "L"-shaped scar in the posterior wall with a 5 cm. defect covered only by serosa.

The classical signs and symptoms of impending and actual rupture often do not appear at all. Ridler (9) reports a previously sectioned patient who was experiencing abdominal discomfort and frequency of urination. There was no shock. Diagnosis of rupture was made on the basis of the history of section plus unusual ease of palpating the fetus through the abdominal wall, and the diagnosis was substantiated at laparotomy. Rankin (10) reports a case who was sectioned because of a somewhat prolonged labor, but without any signs and symptoms of rupture, in whom bilateral fundal tears were encountered on examination of the uterus. A similar experience is noted by Payne (11) who electively sectioned a patient two weeks before term because of a previous classical section. There had been no untoward symptoms of any kind; yet the old scar was found to be separated at its upper angle. Vartan (12) believes that previously sectioned cases may be given a

trial of labor, provided they are hospitalized during the latter part of pregnancy; yet he reports a case who ruptured under his eyes, so to speak, the onset being so insidious that the condition was not recognized in time to salvage the baby. Another patient, reported by Gardner (13), was hospitalized because of burning pain in the right abdomen. She was treated for pyelitis and sent home. Two weeks later she was feeling well, but had not noted fetal movements during this interval. The abdomen was smaller and a flat film of the abdomen suggested the diagnosis of ruptured uterus, which was confirmed at laparotomy. The fetus was macerated and had been extruded through the uterine wall. The placenta, badly degenerated and greenish in color, was still attached to the uterus. Numerous other case reports testify to the fact that the diagnosis of rupture of the pregnant uterus is not always easy, nor does it always follow the text-book pattern outlined above.

Mortality

It goes without saying that rupture of a vascular organ such as the uterus must be attended by serious consequences. There is no need to list the many figures appearing in the literature. Suffice it to say that maternal mortality is variously reported from 40 to 60%, while it is rare for a living baby to be delivered after complete rupture has taken place.

Mortality in rupture of Caesarian scars is relatively low. This may be attributed to several factors according to Dugger (3): First, the diminished vascularity of the area in the region of the ruptured scar prevents excessive hemorrhage; Second, the frequency of occurrence of the accident before the onset of labor or rupture of the membranes, thus reducing the danger of infection; Third, the anticipation and prompt recognition of the condition by the attendant. Thirty-four of the 105 patients who ruptured had one or more previous Caesarian sections. Twenty-seven recovered and seven died. Rupture was spontaneous in fifty-six cases. Of these twenty-one died and thirty-five recovered. In forty-five cases, rupture was traumatic, occurring as a result of some type of manipulation by the attendant. Forty of these patients died and five recovered.

Thus it appears that the most dangerous rupture is that following obstetrical manipulation; second, spontaneous ruptures; while those following previous Caesarian section are more likely to survive.

Treatment

The procedure of choice in all ruptures is transfusion, hysterectomy, or repair of the rent if feasible, and more transfusions. Cases handled conservatively have recovered, and this is especially true in the incomplete ruptures where blood loss may be limited by hematoma tamponade, as in case number 7. Vaginal delivery of the baby following rupture is possible only in very rare instances, and is extremely dangerous.

A good many ruptures may be prevented by proper obstetrical care. If one is "rupture-conscious" and alert to the various predisposing factors as they appear in his patients, he will see that they are delivered in favorable surroundings where emergencies of this nature may be adequately treated. As doctors we can train ourselves to avoid the traumatic procedures which lead to ruptures such as version and extraction in the presence of contraindications, accouchement force, forceps applications through incompletely dilated cervixes and the like. We can refrain from the injudicious use of ergot and pituitary extract. But (1) since the greatest cause of uterine rupture is previous Caesarian section, (2) since there is an increasing number of these cases presenting themselves for obstetrical care, and since there is no unanimity of opinion as to how these individuals should be managed, it seems that our great problem is to adopt a plan of management which will provide the greatest safety for these previously sectioned women.

Primigravidae should be sectioned only for the strictest indications, and definitely not because the family is growing impatient of a prolonged labor with slow progress.

Having decided on abdominal delivery, it is important to consider the type of section which is safest for both mother and baby, not only in the present pregnancy, but in future ones. Phaneuf (14) reviewing rupture of the uterus following previous sections, found that rupture of the classical scar was eight times as frequent as rupture of the scar placed in the lower uterine segment. Lynch (15) expresses the view of most obstetricians today when he states that the classical operation is responsible for a much larger number of ruptured uteri than is the low cervical section. He believes that the low incision heals more perfectly because it is placed in the relatively quiescent portion of the uterus, and is not subjected to the rhythmic contraction and relaxation of the early puerperium. Phaneuf reported forty-one repeat sections in the lower segment. He says that on separation of

the bladder, the lower segment was found to be smooth; there were no depressions or areas of thinning, and the previous scar could not be identified as such. On the other hand, he performed the low operation on thirteen patients who had previously had classical sections. In every case, the old scar was easily demonstrable as a thinner line distinct from the surrounding wall. Greenhill and Bloom (16) reported 93 cases who had had repeat low cervical sections, at the Chicago Lying-In Hospital. In only 16 of these was the previous scar demonstrable at the time of subsequent operation. Rickards (17) is not convinced that location of the incision in the



FIGURE 5—CASE 3

Oblique presentation (Case 3) previously sectioned patient in active labor.

lower segment insures against subsequent rupture, having seen several very thin scars in this region. Furthermore, he feels that if these scars do give way, the consequences are apt to be serious because of lateral extension into the uterine arteries.

The integrity of any uterine scar, regardless of its location, depends largely upon the manner in which the incision is closed. Schwarz and Paddock (18) clearly showed that wound healing in the uterus, as elsewhere, depends upon fibroblastic proliferation. That a perfectly healed uterine scar is not visible, and may be difficult to find even microscopically, is explained by the fact that its ramifications along the line of in-

cision between the adjacent muscle bundles simulate the normal architecture of the uterine wall. Sutures which are placed too tightly, especially in the deepest row, will cause strangulation of the tissue and necrosis, resulting in thinning of the scar. Also, as suggested by Weber (19) and others, it is probable that the granulation tissue thus produced will be more vulnerable to penetration by the trophoblast in subsequent pregnancy. Thus it is essential that approximation of the wound be effected without tension, and that the use of too much suture material be avoided.

Some writers feel that the location of the placenta under the uterine scar tends to weaken it. Morrison and Douglas (20) attempt to visualize the placenta radiographically in all cases of previous section. If the placenta is reported to lie under the scar, the patient is delivered by elective section. Wilson (21) described his method of locating the placenta by abdominal palpation. D'Acerno (22) believes that an underlying placenta is one of the causes of weakness of the scar, but places greater emphasis upon infection, formation of a hematoma in the incision, or inclusion of decidua or serosa within the muscle suture line. He too believes that rupture is much more frequent following classical operation than after the lower segment procedure.

When a woman with a history of previous Caesarian section registers for prenatal care, she usually wants an immediate decision as to whether or not she will have to be delivered by repeat section. Many obstetricians feel that the prior section provides sufficient indication for all subsequent ones. Yet, this attitude can hardly be justified on the basis of cumulative experience. Obviously, if the indication for the previous section still exists, repeat section before onset of labor must be performed. If the previous section was done for a transient indication, considerable information must be obtained from the patient's doctor and hospital: 1) indication for operation; 2) type of section performed; 3) clinical course postoperatively; 4) whether or not wound infection occurred; and 5) postoperative temperature curve.

King (23) feels that if the previous operation has been a classical section, repeat abdominal delivery should be decided upon. It is generally agreed that repeat section is the procedure of choice if the patient gives a history of a febrile postpartum course, on the assumption that it resulted from intrauterine infection. History of

infected abdominal wound would be a potent indication for repeat section.

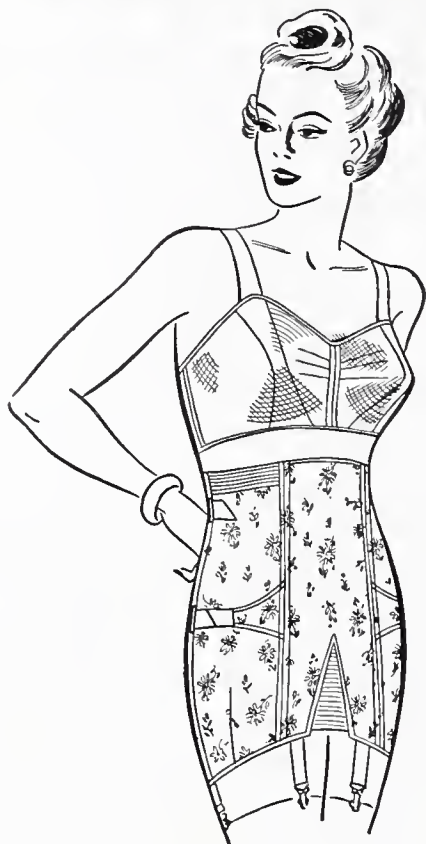
Unless a positive indication is found in the patient's history, it may be elected to postpone a decision in order to evaluate the pregnancy nearer term and attempt to predict what sort of labor might be anticipated. An important point in the history is whether or not there has been a previous vaginal delivery. Other factors which must be studied are: engagement or non-engagement of the presenting part, size of the baby, presentation, adequacy of pelvic measurements, location of the placenta, character of the cervix (consistency, length, dilatation), and presence or absence of pain in the region of the previous incision. It should be noted that one or two vaginal deliveries following a Caesarian section does not mean that the threat of rupture in subsequent pregnancies can be overlooked. Tollefson (24) emphasizes the point that there is a tendency to become careless in cases where there have been previous vaginal deliveries. He is inclined to favor repeat sections as a routine. Taylor (25) also warns against placing any confidence in a uterine scar simply because it has withstood one or two labors. He cites cases in which the scar has held for the first or second delivery after previous section, only to rupture at a subsequent one. Thornhill (26) reports a patient whose previously sectioned uterus remained intact throughout a very difficult labor and delivery, and who subsequently ruptured during an easy premature labor.

Many authors advise hospitalization a week or two before the expected date of confinement, but this is hardly practical in these days of crowded maternity divisions and high hospital costs. Besides, the plan does not insure against rupture, as shown by the case of Vartan's which was mentioned before. Of much greater importance is close observation of the patient when labor begins. If one decides to let his previously sectioned patient try labor, he must plan to sit with her throughout its course. Only in this manner may he diagnose impending rupture in time to section her. Responsibility for making such a diagnosis can never be left to nurses or interns, and it seems obvious that if a case cannot be managed in this way, it is the better part of valor to perform an elective, repeat Caesarian. It goes without saying that every woman with a history of section in a previous pregnancy should be typed and have compatible blood instantly available for her.

Summary and Conclusions

1. Six cases of rupture of the pregnant uterus are reported, five having occurred during the

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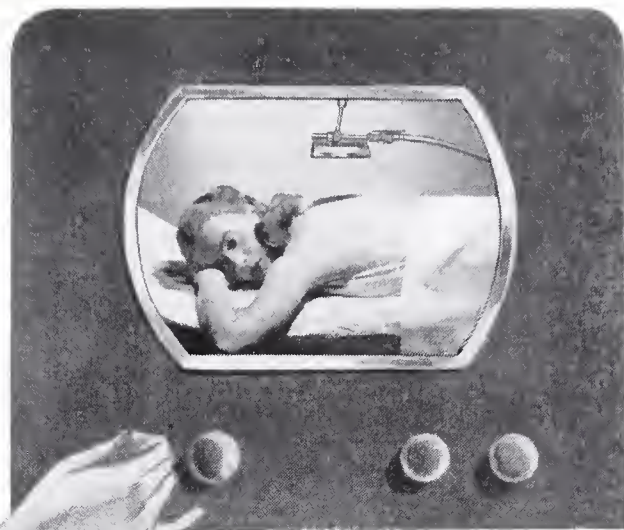
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past 3 years, in the course of approximately 6,000 hospital deliveries. There were no maternal deaths; one of the babies survived.

2. Review of the literature reveals the most important causes of this accident to be; previous Caesarian section, obstetrical manipulation and the injudicious antepartum use of oxytocic drugs, in that order.

3. More conservative obstetrical technic will reduce the incidence of traumatic rupture.

4. Previously sectioned patients must be carefully watched during subsequent labors for signs of impending rupture; preparations for transfusion and abdominal delivery must have been made in advance. Careful prenatal evaluation of these patients will usually determine which should be delivered by repeat elective section and which may be allowed a trial of labor.

5. Careful postpartum exploration of the uterus should always be done following version and extraction, difficult forceps delivery and vaginal delivery of a previously sectioned patient.

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Chrm. Awards Committee.

ANTICOAGULANTS IN HEART DISEASE *

R. E. McLOCHLIN, M.D.
Little Rock

I do not intend by this paper to add anything new or give any definite contribution to your medical knowledge, but simply hope to impress upon you the necessity of, we doctors practicing in Arkansas to become more aware of the proven value of the use of anticoagulants in our handling of heart cases, particularly coronary occlusion and myocardial infarctions.

In 1938 Solandt, Nassim and Best were able to prevent the development of coronary thrombi and intracardiac mural thrombi, by methods which would usually produce thrombi in experimental animals, by the use of heparin. By injecting sodium ricinoleate into an isolated section of a dog's coronary artery which was clamped off for 10 minutes following the injection, they produced a slowly progressive thrombosis and myocardial infarction in 12 of 13 animals. In a similar series of 12 animals given sufficient heparin to markedly prolong the coagulation time, infarction occurred in only one. They suggested that heparin might be used therapeutically, but their observations were not applied to man or any significant scale because of the difficulties and the risks felt to be inherent. It was not until 1945 and 1946 when (Wright, Nichol and Page) and (Peters, Gugther and Brambil) reported encouraging results in the use of the anticoagulant, dicumarol, in the treatment of coronary thrombosis with myocardial infarction in man that such interest has been taken and strides made in the use of such drugs in these conditions. In fact, their reports, although preliminary in nature, were so encouraging that the Board of Directors of the American Heart Association, in the spring of 1946 authorized the formation of a committee for the Evaluation of Anticoagulants in the treatment of Coronary Thrombosis with Myocardial Infarction. This Committee is composed of internists with special interest in cardio-vascular diseases working in sixteen of the leading hospitals in the country. A recent report of their results, obtained by a statistical analysis of the first 800 cases studied, show a decided value in the use of anticoagulant therapy in conjunction with the conventional method of therapy, both as regards incidence of death and thrombo-embolic complications.

They concluded that anticoagulant therapy should be used in all cases of coronary thrombosis with myocardial infarction unless a definite contraindication exists. They found that patients treated with anticoagulant therapy experience a death rate and incidence of thrombo-embolic complication during the first six-week period following an attack to a markedly lower extent, than those experienced by patients treated solely by conventional methods.

With the high and apparently increasing frequency of coronary thrombosis and myocardial infarction in our aging population, we in Arkansas must become cognizant of any and all improvements or advancements in our method of handling such cases. The conventional methods now in use, which are largely only supportive and symptomatic, doubtless facilitate survival in many cases, yet the average mortality of about 20% during the first attack manifestly leaves much to be desired.

So far as the underlying pathological changes in the coronary arteries are concerned very little of a curative nature can be accomplished, also prophylactic measures are very inadequate. The myocardium, however, has remarkable recuperative powers if the initial attack is not too grave. If the infarcted area is so extensive that it quickly results in congestive failure, profound shock, or serious arrhythmias, death may often be inevitable. However, a substantial number of such cases may survive this severe initial attack only to succumb later as result of extension of the original thrombus and increase of the infarcted area, or thrombosis in other coronary arteries or of emboli in the pulmonary, cerebral or other systemic arteries. It is with these possibilities in mind that anticoagulants may be of great aid in preventing, and thereby cause a greater percentage of these cases to survive this particular episode.

The major deterrent factor in the more frequent use of dicumarol to date is inadequate laboratory facilities for the determination of prothrombin time which is necessary for proper control of dosage of the drug. In fact, it has not yet been accurately determined the maximum level for prothrombin time for optimal results, careful studies are now being conducted in these 16 major hospitals in an attempt to determine results with various levels being maintained. Our information so far is based upon maintaining a prothrombin time of from 10 to 30% of normal.

On the basis of our present knowledge, therefore, as reported in the literature, every case of coronary occlusion with coronary infarction

* Read before the Seventy-Third Annual Session, Arkansas Medical Society, Little Rock, April 14, 1949.

should be hospitalized, and among the usual conventional forms of therapy an emergency prothrombin determination should be made and dicumarol administered soon as practicable. Heparin may be given for the first 48 hours if desired in order to obtain a more rapid effect. Sufficient dosage of heparin should be given to increase the coagulability of the blood three times the pre-therapy level. Dicumarol is also started at once in dosage of 200 to 300 mg. daily until the prothrombin time is 20-30% of normal. Then a maintenance dose of 50 to 100 mg. daily provided the prothrombin time does not get over 35 seconds. This therapy should be continued for a period of three to four weeks after the last thrombo-embolic episode.

The principle complication of such therapy of course is hemorrhage. This may be in the form of hematuria, hemoptysis, hematemesis, melana, or epistaxis. Synthetic vitamin K preparation (60 to 75 mg.), or transfusions will usually control these very well.

I recently attended a post-graduate course in cardio-vascular diseases at the Massachusetts General Hospital under the direction of Dr. Paul White and among other very excellent lectures we had one on coronary artery disease by Dr. Sam Levine. He is very enthusiastic regarding the use of dicumarol and on the basis of his comparatively vast experience with it, and the dosage that he has found most often indicated under careful control, he made a rather startling statement. This statement was to the effect that in event the laboratory facilities are not available for prothrombin studies that a patient could be given 300 mg. the first day, 150 mg. the second day and 50 mg. daily thereafter for 3-4 weeks, and simply watch carefully for hemorrhage; i.e., hematuria, epistaxis or possibly from the bowel. In other words, he meant to leave the impression that he felt the use of anticoagulant was that important.

NOTES FROM UNIVERSITY OF ARKANSAS SCHOOL OF MEDICINE

A gift of \$500,000.00 from the William Buchanan Foundation, of Dallas, Texas, will provide a pediatric floor in the new medical center, to be known as the William Buchanan Pavilion for Children. This grant with matching federal funds will increase the bed capacity of the new hospital from 400 to 500 beds. In addition to the 500 beds, there will be provided a rapid treatment unit for neuropsychiatric patients; the number of beds for this unit has not yet been determined. Plans for the proposed new hospital and medical school building are being drawn and construction will commence before the end of 1950. It is expected that other units will be constructed and occupied simultaneously with the building of the hospital and school.

A grant of \$3,000.00 has been received from Hoffman LaRoche, Inc., for the study of anticurara compounds under the direction of Dr. Lloyd D. Seager, head of the department of physiology and pharmacology, and Dr. E. L. Rushia, head of the department of anesthesiology. Abbott Laboratories has granted \$1,200.00 for the study of synergism of trypanocidal drugs, which investigative work will be carried on by Dr. Seager.

The United States Public Health Service has given the Department of Radiology a grant of \$12,000.00, to be used for radiologic cancer control. The principal investigator in this field is Dr. I. Meschan, head of the department of radiology.

A grant of \$635.00 from the Schering Corporation supported a color plate publication of a rare tumor in a one-year child. Dr. H. N. Marvin, of the department of anatomy; and Dr. Vida H. Gordon, of the department of pediatrics, were the recipients of this grant.

Dr. John S. Poe, formerly connected with Columbia University College of Physicians and Surgeons, has been appointed professor of neuropsychiatry and head of the department of Neuropsychiatry, effective May 1, 1950; Dr. H. Lee Hall, formerly associated with the Long Island College of Medicine, has been appointed associate professor of neuropsychiatry, effective July 1, 1950.

Dr. John R. Trotter, associate professor of biochemistry, has been granted a leave of absence of five months, beginning March 20, to participate in the research program at the Oak Ridge Institute of Nuclear Studies, Biology Division.



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EDITORIAL

A ONE-SENTENCE EDITORIAL

The problem is no longer socialized medicine but socialism in all phases of American life.

DEPARTMENT OF AMPLIFICATION

"Of course, it is not socialized medicine. It is nothing of the kind. It is national health insurance, paid for, just as social security is PAID FOR." (Emphasis ours—Ed.). From an address by Jacob S. Potofsky, presenting the Sidney Hillman Foundation award for meritorious public service to Oscar Ewing, March 11, 1950, from Congressional Record, March 13, 1950, A1953-1954.

DON'T BE A BYSTANDER

The doctor can choose between giving his best and his most intelligent support to the voluntary health plans, or accepting the inexorable fate of socialization. He has no middle course.

The doctor must stop being a bystander as

far as the voluntary health plans are concerned. What they are doing and how they are doing it, what they are offering and how they are offering it, are things that concern him more than anybody else.

The survival of a medicine of free choice depends on its being brought in line with the economics of this century. The voluntary health plans offer the doctor the means for doing that. —Lawrence Drake, in Jackson County (Missouri) Medical Bulletin, January 28, 1950.

THE PUBLIC PURSE

We read with much interest a monthly letter issued by The Pioneer, formerly the Democrat Printing and Lithographing Company in Little Rock, and because the thoughts expressed so well in the November, 1949 issue, should be of concern to all Americans, we print herewith extracts from that letter.

"We believe that the only thing wrong with the world is the people in it. Extermination, atomic or otherwise, is obviously too drastic; but practically as much could be accomplished if we could find some way to operate on people's minds to remove the urge for individual or group short-range selfishness.

"This rat-race, wherein each segment of the public keeps trying to get all the public to ease them out of their little difficulties, is by now, much more pathetic than ridiculous. Can't people realize that they constitute the public, and that the public purse is their purse?"

Thanks for the thought, Frank Parke, and we hope its appearance here helps to encourage us to rely on each other, on local strength, and not on the "government," which happens also to be us.

SURVEY OF PHYSICIANS' INCOMES

Late in April the Bureau of Medical Economic Research of the American Medical Association and the Office of Business Economics of the U. S. Department of Commerce will jointly conduct a survey of physicians' incomes.

The Bureau has been authorized by the A.M.A. Board of Trustees to cooperate in this survey, which the Department of Commerce had planned to conduct alone. It will be the first full-scale survey by the department of physicians' incomes since 1941.

An analysis of the results will be published by the Department of Commerce next fall in its monthly publication, "Survey of Current Business." Its August, 1949, and January, 1950, is-

sues had published similar analyses of surveys of incomes of dentists and lawyers, respectively, made jointly with the American Dental Association and the American Bar Association.

There is evidence that the national averages in some surveys have been too high because physicians who do not have bookkeepers to fill out questionnaires do not reply in sufficient numbers. Accordingly, the Bureau emphasizes the importance of all doctors, especially those with a relatively small practice, filling out the questionnaires.

Accurate postwar data on physicians' incomes is badly needed in order to develop better estimates of how much the American people pay to physicians.

Every physician can be assured that the survey has no relation whatever to the operations of the U. S. Bureau of Internal Revenue. There is no way by which the Department of Commerce could have obtained the needed information from the Bureau of Internal Revenue; hence, the questionnaire survey.

There will be two questionnaire forms. The Bureau of Medical Economic Research helped to design these. A short form will request income data for 1949 only. A long form questionnaire will cover the years 1945 through 1949. All are to be returned unsigned in franked envelopes.

The punch card files of the Bureau of Medical Economic Research contain the names of about 200,000 physicians. The survey will cover 125,000 of these, or 62½ per cent of the total. Selection will be by a formula which eliminates any partiality.

A short form will be sent once only to **every other** name in the file. Of the remaining 100,000 names, every fourth will be selected. To these will go 10,000 short forms and 15,000 long forms, with this distinction—the return franked envelopes will carry a code number which will identify the physician to the Bureau of Medical Economic Research alone. All of the addressing will be done in the headquarters of the A.M.A.

The sole purpose of the code number is to enable the Bureau of Medical Economic Research to address a follow-up letter to those not replying to the first request. Physicians need have no suspicion about the code number because when the reply is received, the questionnaire will be separated immediately from the envelope and the identity will be lost.

Physicians will be doing the medical profession a service by filling out the forms and returning them as soon as possible.

RANDOM THOUGHTS OF THE SECRETARY

February 19th. Visiting an ill colleague in New Orleans' Foundation Hospital, finding that Mardi Gras affects hospital and medical care in some slight degree as this old city enters whole-heartedly into the spirit of "carnival," and we depart, hoping that we have not become too blase over parades, masking and the like which attend this period of gaiety.

February 25th. Tonight sponsoring with Earle Hunt a surprise party for Earle Woodson at Poteau, the party engineered because our many requests and hints that Woodson himself give the party fell on fallow ground. Merriment is abounding and Woodson charitably "hopes" that we can all get together again before another year rolls around.

February 27th. Today we ask Oklahoma's Graham to arrange for us to hunt the escaped leopard, a quest in which Dick evidences little enthusiasm.

February 28th. Another wild Oklahoman runs afoul of the law but we rather think of the leopard as the victim of a government hand-out and perhaps there may be a moral here.

March 5th. With all the state's roentgenologists but two in attendance, gathering at D. A. Rhinehart's where there gaiety, good fellowship and great food, although we cannot concede that this is better than Lucy's tamale festival.

March 10th. With Krock and Hodges over the miles to Mountain Home where there are willing helpers and interesting cases at the diagnostic cancer clinic, conducting the postmortem, the most hospitable moment of the day with the Hutchesons and Tiptons and homeward with an inner consciousness that perhaps we have done some good in return for the courtesies and pleasantries extended us during the day.

March 20th. Just because it seems a good idea we drive with Peggy and the Weston Prices down Highway 10 to Little Rock, visit with the Bill Shepherds out Mabelvale way, call briefly on the Ben Ames, also lay friends, eat well at the Marion, our pleas that we court what the group terms certain rebuff at the King's Smorgasbord because we wear a casual scarlet jacket and not a coat, being vigorously opposed, and so homeward with much less enthusiasm.

March 21st. Charles Henry is our overnight guest, stirring our flagging spirits by recount of the fifty per cent effort exerted by the medical profession in public education and together we hope for greater interest by more members.

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TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

WITH the tuberculosis death rate dropping so rapidly, the question is sometimes asked why larger amounts are needed each year for the control of this disease. The answer, in a nutshell, is that eradication of tuberculosis in this country within a relatively few years is now the goal. In the past the best that one could attempt was to keep the disease under control. It now appears that with the concentrated effort of all interested groups, tuberculosis may be conquered in most communities in the foreseeable future.

TB—THE COSTLY DISEASE

If tuberculosis is to be eradicated, adequate facilities must be made available for chest X-rays of all apparently healthy adults, for suitable follow-up of all cases needing further study, and for medical care.

Sufficient hospital beds must be made available to insure care and isolation for all persons with active disease; adequate financial provision must be made for the families of hospitalized patients; funds must be at hand to insure the rehabilitation of ex-patients. Above all, health education must be carried to a far greater proportion of the population. Medical research must continue on many fronts. Pensions must be provided for tuberculous veterans. All these facilities and activities require vast sums of money both from official and voluntary sources.

Best estimates indicate that in 1948 the tuberculosis control program in the United States cost approximately 350 million dollars. This amount makes no allowance for hospital construction, for depreciation of hospital buildings, or for the training of professional personnel.

The Public Health Service appropriation for tuberculosis control is now about ten million dollars annually; the Christmas Seal Sale is more than 20 million dollars; state health department funds for tuberculosis work have increased materially in the past decade. The Veterans Administration is now spending much more on hospitalization and rehabilitation of the tuberculous. Pensions for veterans whose major disability is tuberculosis amounted to 86 million dollars in the calendar year 1947.

Not only are official and voluntary health agencies spending huge amounts on community-wide X-ray surveys, but industrial firms and labor

unions are financing projects of this type. Moreover, in recent years it has become necessary to devote large sums to the recruitment and training of executive and professional health workers.

In addition to the estimated annual cost of approximately 350 million dollars, so-called "hidden costs" of tuberculosis run well into the hundreds of millions. Among these costs are the potential annual losses in wages, in production, and in net future earnings incurred by those persons who die or are incapacitated by tuberculosis. Since these estimates overlap to some extent, no total can be shown for potential losses of this type.

A study made in 1943 estimated that the potential loss of wages in that one year by those who were ill or who died of tuberculosis was nearly 200 million dollars. The potential loss of goods and services which might have been produced in that year was 350 million dollars. There is, in addition, a potential loss in the net future earnings of those who died in 1943 which came to more than 200 million dollars.

None of these estimates makes any allowance for the cost of the many thousands of new beds needed. This cost would come to approximately 200 million dollars for about 40,000 new beds; if the 80,000 beds, said by certain authorities to be needed, were to be built, the estimated cost would be 400 million dollars. Such an enormous outlay may be considered justified, even in the face of a rapidly falling tuberculosis death rate, since at the end of a decade or two the hospitals would be available for chronic disease patients. Such facilities will become increasingly necessary since our population is aging rapidly. Moreover, in view of accelerated world travel, it will still be necessary some years hence to appropriate a

moderate amount to maintain hospital and other facilities for tuberculosis control.

The tuberculosis death rate has now dropped to 30 per 100,000 population in the country as a whole, compared with a rate of 194 in 1900. The sensational decline in the over-all mortality rate from this disease during the past five decades has tended to obscure the fact that the death rate varies widely according to sex, age, color, economic status, and locality. Thus, the death rate of 30 must be accepted as an average only.

Mortality from tuberculosis is twice as high among men as among women. It increases directly with age and is especially high among older men. The death rate among Negroes is three times as high as among white people. In one state, the death rate is still 100, while one or two states now have rates of less than 10. Similarly, a few of our large cities have outstandingly high rates. Mortality is seven times as high among unskilled laborers as among professional persons. Thus it is evident that in numerous groups a great deal of concentrated effort must be exerted if the disease is to be brought under control at any time in the near future.

For all these reasons, the cost of tuberculosis control cannot be lessened in any community until its tuberculosis death rate reaches a level of less than 10 per 100,000. When that goal is attained, it is possible that much of the available funds may be diverted to other phases of health work. Until then, no let up can be planned.

Editorial, Mary Dempsey, Statistician, National Tuberculosis Association, Bulletin of the National Tuberculosis Association, December, 1949.

RESOLUTION

WHEREAS, the all-wise Providence has seen fit to remove from our midst our valued co-worker and a faithful member of the Pulaski County Medical Society since 1941, Dr. Don W. Dykstra, we, the members of the Society mourn and deeply regret his sudden death.

WHEREAS, in answer to a call of service from his country's leaders during the second world war he gave of his skill and energies unstintingly and at great personal sacrifice.

WHEREAS, as a physician in his chosen field of public health and general practice of medicine he attained a great measure of distinction and won the respect of his colleagues as well as the gratitude and love of a host of sorrowing people.

BE IT RESOLVED, that the Pulaski County

Medical Society express to his family the esteem in which he was held as a member of the Society and its heartfelt sympathy to the family at the untimely loss that they have sustained; that a copy of this resolution be made a matter of record in the minutes of this meeting; that a copy be sent to the family and a copy be sent to the Journal of the Arkansas Medical Society.

This Resolution is respectfully submitted to the Society by your Committee.

Wm. P. Scarlett, M.D.,

Mason G. Lawson, M.D.,

H. M. Hamlin, M.D.

OBITUARY

FELIX EASLEY BAKER, age 78 years, died at Stamps November 20th, 1949. A graduate of the Memphis Hospital Medical College in 1896, he was an honorary member of the LaFayette County Medical Society and of the Arkansas Medical Society and a member of the Fifty-Year Club. He was also a druggist and a vice-president of the Bowcaw Bank. He served for many years as county health officer.

ARTHUR G. EMERSON, age 76 years, died at his home in Bald Knob February 2nd, 1950, after an illness of five weeks although ill health had prevented a more active practice for the past five years. A graduate of the University of Nebraska College of Medicine in 1901 he had practiced at Bradford and Bald Knob for over twenty years. Surviving relatives are his wife, a son, two brothers and a sister.

ERNEST LINDRELL THOMPSON, age 72 years, died at his home in Hot Springs National Park February 14th after an acute illness although he had been in ill health for several years. He was born at Milan, Tennessee, October 22, 1877, and attended George Peabody College, Nashville, and graduated from University of Nashville Medical Department in 1902 and had practiced in Hot Springs National Park since graduation, being associated with his father and an uncle. He was formerly city and county physician and track physician for the Oaklawn Jockey Club, and had served as medical director for the Hot Springs sanatorium. Surviving are his wife, a past-president of the Woman's Auxiliary to the Arkansas Medical Society, two sons and a sister.

PROCEEDINGS OF SOCIETIES

The Tri-County (Clark, Hempstead and Nevada) County Medical Society has been reorganized with the following officers: President, J. W. Kennedy, Arkadelphia; vice-president, J. W. Branch, Hope, and secretary-treasurer, L. J. Harrell, Prescott. Meetings will be held each month alternating in the counties.

Ouachita County Medical Society met in dinner session at Camden on March 2nd, with the following scientific program: "External Version," John W. Jones, Texarkana and "Office Urology," Gerald Teasley, Texarkana.

Craighead-Poinsett County Medical Society met in Jonesboro on March 1st, with the following scientific program: "Pediatric Problems," Walter L. Ruck and Blake Arnoult, Memphis.

The Second Councilor District Medical Society met at Batesville March 8th for the following program: "An Improved Diagnostic Concept Regarding Some Intrathoracic Lesions," J. K. Donaldson, Little Rock; "Pediatric Problems," B. P. Briggs, Little Rock; "Acute Obstetrical Emergencies," Clyde D. Rodgers, Little Rock. Following dinner addresses were made by Earle H. Hunt, Clarksville, "Socialized Medicine," and J. J. Monfort, Batesville, "Medical Legislation."

PERSONALS AND NEWS ITEMS

E. C. Moulton, Jr., Fort Smith, spent a recent vacation at Aspen, Colorado.

Guy Shrigley, Clarksville, spent a recent vacation in Florida.

The following were registered at the Saint Louis session of the American Academy of General Practice, February 20-24th: O. H. Clifton, Rector; R. B. Robins, Camden; F. S. Dozier, Marianna; S. A. Drennen, Stuttgart; C. Randolph Ellis, Malvern; L. J. Evans, Batesville; W. A. Fowler, Fayetteville; J. G. Gladden, Harrison; R. D. Hawkins, McGehee; G. L. Kimball, DeQueen; C. C. Long, Ozark; J. P. McAlister, Camden; M. D. McClain, Little Rock; L. H. McDaniel, Tyronza; A. H. Maddox, Paragould; Fount Richardson, Fayetteville; B. N. Saltzman, Mountain Home; E. M. Smith, Hot Springs National Park; R. H. Whitehead, DeWitt, and Thomas Wilson, Wynne.

R. B. Robins, Camden, has been reelected

Speaker of the House of Delegates, American Academy of General Practice.

George Steinkamp recently addressed the Medical Dames, Little Rock, on compulsory health insurance.

Euclid M. Smith, Hot Springs National Park, addressed the recent Saint Louis session of the American Academy of General Practice on "The Role of Spa Therapy in the Management of Rheumatic Diseases."

Fred Gordy, Jr., has been elected president of the Conway Country Club.

The following attended the recent regional meeting of the American College of Surgeons in Louisville: Roy Millard, Russellville; H. Fay H. Jones and Jos. F. Shuffield, Little Rock; A. D. Cathey, El Dorado, and Frank Reid, Pine Bluff.

The following attended a post-graduate study course in tropical medicine at Tulane University during February: J. E. Johnson, Fort Smith; W. H. Bruce, Pine Bluff; J. H. Summers, Little Rock; A. B. Tate, Russellville and B. M. Stevenson, Helena.

George Burton, El Dorado, has been elected councilor from Arkansas to the American College of Radiology.

In attendance at the New Orleans Medical Assembly were: G. E. Cannon, Hope; Harry E. Murry, Texarkana; B. N. Saltzman, Mountain Home; O. R. Kelly, Sheridan, and Carl L. Wilson and W. L. Shippey, Fort Smith.

Dr. and Mrs. Paul L. Mahoney, Little Rock, spent a recent vacation in Florida.

"Why Medical Economics?" by R. B. Robins, Camden, appeared in the March issue of the Southern Medical Journal.

J. Harry Hayes, Little Rock, attended the annual session of the American Goitre Association at Houston on March 9th, 10th and 11th.

The following were registered at the recent session of the Dallas Southern Clinical Society: E. B. Burt, Magnolia; R. H. Coleman, Little Rock; Chas. W. Dixon, Gould; L. Murphey Henry, Fort Smith; J. J. Monfort, Batesville; Mac Mc-

Lendon, Marianna, and Cecil Riggall, Prairie Grove.

"Pentothal Sodium in Anorectal Surgery," by Ralph E. Crigler, Fort Smith, appears in *The American Journal for Surgery*, January, 1950, issue.

BORN—on March 12th, Dianna Hires Olson, to Dr. and Mrs. J. D. Olson, Fort Smith.

T. P. Foltz, J. C. Hodges, A. F. Hoge and M. B. Hoge have moved into new offices at 1600 Rogers Avenue, Fort Smith.

R. B. Robins, Camden, addressed a joint meeting of the Virginia Academy of General Practice and the Richmond Academy of Medicine at Richmond March 28th.

Willis E. Brown, Little Rock, addressed the Dallas Southern Clinical Society March 13th on "Practical Endocrine Therapy in Gynecology."

BORN—On March 23rd, a son, to Dr. and Mrs. W. M. Woods, Huntington.

The following were elected as outstanding citizens in the Arkansas Democrat's Magazine poll for 1949: J. D. Riley, Carl A. Rosenbaum, Earle D. Parsons, Ellery C. Gay, Corydon Wasell, Paul L. Day, George W. Jackson and Eva Dodge.

Dr. and Mrs. C. W. Hall, Greenwood, spent a recent vacation in Colorado and Wyoming.

R. B. Robins, Camden, recently addressed the Fordyce Rotary Club on "The Menace of Socialized Medicine."

Asa C. Watson, Jr., has opened an office for the practice of obstetrics and gynecology at 1216 Pennsylvania Avenue, Fort Worth.

The Sebastian County Medical Society was addressed March 14th by Homer A. Ruprecht, Oklahoma City, on "Auricular Fibrillation."

M. B. Hoge, Secretary.

Eva F. Dodge, Little Rock, and Chas. R. Henry, Little Rock, recently addressed a sociology class at the University of Arkansas, Fayetteville, on the anatomy and physiology of reproduction, antepartum care, delivery and postpartum care.

THE DOCTOR AND ELECTION DAY

Physicians can't win their fight by staying away from the polls on election day, Charles S. Nelson, executive secretary of the Ohio State Medical Association, said at the Second National Conference on the A.M.A. Education Campaign in Chicago recently.

Mr. Nelson provided some startling facts which show the medical profession's inertia at election time.

"Let me give you some almost unbelievable data which has been uncovered in Ohio," Mr. Nelson said, adding:

"After the surprise party which Mr. Truman threw in November, 1948, some of the political leaders in Ohio decided to hold a postmortem. They selected one of Ohio's industrial areas—Summit County, including the city of Akron. The records of the county board of elections were scrutinized. Believe them or not, here are some of the findings:

"18% of the physicians of the county did not vote in the 1948 election—13% of them were not even registered and therefore not eligible to vote.

22% of the wives of physicians did not vote—16% of them were not registered.

"10% of the members of the Rotary Club did not vote—3% were not registered.

"The tally on Kiwanis Club members was about the same.

"18% of the druggists did not vote—15% were not registered.

11% of the teachers did not vote—6% were not registered.

"32% of the bank employees, including executives, did not vote—26% were not registered.

33% of the ministers did not vote—26% were not registered.

"34% of the retail grocers did not vote—29% were not registered.

"Here's one for the books: 21% of the members of the Chamber of Commerce did not vote—15% were not registered.

"I could give you additional statistics. However, these will suffice to show why we are bearing down on registration of voters and voting this year. We're sure that similar data could be uncovered in other parts of the state.

"Elections are still won by votes, strange as that may seem to some people.

"And, the politician still has a warm spot in his heart for groups which vote and produce votes. If you doubt that, just ask one."

WOMAN'S AUXILIARY NEWS

The Sebastian County Woman's Auxiliary held a luncheon meeting in Fort Smith on March 8 with Mrs. T. P. Foltz, vice-president, presiding. Mrs. Kenneth Thompson, president, is in New York with Dr. Thompson.

Mrs. J. B. Stewart and Mrs. W. L. Shippey were elected delegates to the Convention.

A contribution of five dollars was made to the Jane Todd Crawford Memorial Fund.

Mrs. Ben H. Pride,
Publicity Chairman.

Mrs. Davis W. Goldstein and Mrs. Walter Eberle were hostesses at the February meeting of the Sebastian County Medical Auxiliary. The president, Mrs. Kenneth Thompson, presided over a short business meeting. Mrs. Thomas P. Foltz, program chairman, gave a brief outline of plans for the State Convention.

Mrs. Ben H. Pride,
Publicity Chairman.

The Auxiliary to the Hot Springs County Medical Society met with the doctors for a joint dinner meeting on February 10 at the Barlow Hotel. Dr. and Mrs. Herman L. Brown were host and hostess for the meeting. Guests for the evening were Dr. and Mrs. J. Donald Hayes of Little Rock. After dinner the Auxiliary held a short business meeting and elected the following officers: President, Mrs. John W. Cole; vice-president, Mrs. C. R. Ellis; secretary-treasurer, Mrs. N. B. Kersh. Plans for Doctor's Day were discussed, after which a delightful social hour was enjoyed.

Mrs. C. R. Ellis, Secretary.

The Woman's Auxiliary to the Union County Medical Society met February 7th at the Garrett Hotel. Fourteen members were present. After dinner a business meeting was held. Hostesses for the evening were Mrs. J. H. Pinson and Mrs. Berry Moore.

Mrs. George Burton.

The Garland County Medical Auxiliary held its monthly meeting with a luncheon at the Arlington Hotel February 9th with thirty-two members attending.

The president, Mrs. Leeman King, presided over a short business meeting and appointed the following Nominating Committee:

Mrs. A. A. Smith, Mrs. H. King Wade, Sr., Mrs. Turner Wooton and Mrs. D. B. Stough.

Col. Ralph Patterson of the Army and Navy

Hospital gave an interesting talk on Arthritis.

The tables were beautiful with red hearts and silver candelabrum with red tapers at the speaker's table.

The March meeting will be a coffee at the home of Mrs. L. E. Reed.

Mrs. L. E. Reed,
Publicity Chairman.

A spring garden scene set the theme for the presentation of the latest in fashions for 1950 at the fourth annual benefit tea and style show given by the Jefferson County Woman's Auxiliary, February 18, from three until five at the Hotel Pines.

Against a soft blue backdrop tall evergreens were massed at each side of the stage. Hyacinths and azaleas in pastel shades were set along a low white stone wall, and urns of trailing ivy bordered the garden path. Models entered through a wrought iron gate to display thirty ensembles down the aisles of the main ballroom. Following the review favors were distributed to the 350 guests.

Mrs. R. D. Dickens, president of the Auxiliary, welcomed the guests and officiated at the drawing for door prizes.

After the fashion show the audience remained for tea. In the center of the room was the beautifully appointed table covered with a hand-made white organdy cloth. Centering the table was a silver epergne arranged with white and yellow snapdragons, jonquils, dutch iris and acacia. Long white tapers were in silver candelabras. Proceeds from the tea were used to purchase louvered doors for the Davis Hospital.

Mrs. Ross E. Maynard, Secretary.

The Jefferson County Medical Auxiliary met March 3 at the Pine Bluff Country Club. The following officers were elected to serve for the year 1950-1951.

President—Mrs. Howard Stern.

President-Elect—Mrs. Clyde Hart, Jr.

Vice-President—Mrs. Chas. Reid.

Secretary—Mrs. Ross E. Maynard.

Treasurer—Mrs. George Talbot.

Parliamentarian—Mrs. R. D. Dickens.

Publicity Secretary — Mrs. T. J. Cunningham, Jr.

Plans were made to observe Doctors' Day on March 30th.

Mrs. Ross E. Maynard, Secretary.

The Auxiliary to the Independence County Medical Society was held March 8 at the Bates-

ville Country Club following dinner with the members of the District Medical Society.

The Auxiliary was privileged to hear Dr. Earle Hunt of Clarksville on the subject of general as well as medical socialism. After Dr. Hunt's talk we met and heard Mr. Sid Wrightsman, who is executive secretary of the Arkansas Medical Society.

We then withdrew to a business meeting of our own in which the principal problem was the working out of plans for the coming Doctors' Day, March 30, 1950. Mrs. L. T. Evans, president, heard and accepted readings of the Minutes and Treasurer's Report. Then followed committee reports in preparation for the yearly report of the Auxiliary. The Nominating Committee reported their choice for officers for 1950-1951, and the only change was the president, who will be Mrs. C. G. Hinkle. The vice-president remains Mrs. W. H. Calaway; secretary, Mrs. C. A. Taylor and the treasurer, Mrs. W. J. Ketz.

Guests for the evening were Mrs. Orville Carter, County Health Nurse; Miss Alene Shwindler, Anesthetist for local N. Ark. Clinic; Mrs. John Harkleroad, R. N., owner and manager of the local Allen's Hospital.

Mrs. Chas. A. Taylor, Secretary.

Mrs. Louis K. Hundley, Pine Bluff, president of the Woman's Auxiliary to the Arkansas Medical Society, was honored at a luncheon at the Washington Hotel by the Washington County Auxiliary. She was scheduled to speak to the county unit at a meeting after the luncheon at the home of Mrs. Fount Richardson.

The Pope-Yell County Medical Auxiliary met at the home of Mrs. Ellis Gardner on Thursday night, March 9th, for a dinner meeting.

The president, Mrs. Roy S. Millard, presided over the business meeting. The newly elected officers are: President, Mrs. A. Watson Miller; vice-president, Mrs. W. O. Young; secretary-treasurer, Mrs. Brooks Teeter.

Mrs. Roy S. Millard and Mrs. A. Watson Miller were appointed delegates to attend the State Medical Auxiliary in April. Two new members were present, Mrs. Walter Lane of Dover and Mrs. Ernest King of Russellville.

Mrs. William O. Young, Secretary.

The Washington County Medical Auxiliary met February 17th at the home of Mrs. J. W. Stocker. During the business meeting plans were made for our April meeting at which time

we will have Dr. George Benson as guest speaker. This meeting will be open to the public. March 23 has been designated as Doctor's Day.

Mrs. Fount Richardson, President.

The Auxiliary to the Southeast Arkansas Medical Society met in Monticello February 20. After dinner with the doctors at the Ridgeway Hotel the ladies met in the home of Mrs. Robert Hyatt for a business meeting.

Mrs. Bryan Barlow of Dermott presided. Doctor's Day observance was discussed at length. Plans were announced to have election of officers at the March meeting.

Mrs. Louis K. Hundley, state president, who was present, asked the Auxiliary to name someone to be given special honor at the state meeting. This was done.

The meeting adjourned and an enjoyable social hour followed.

Mrs. Van C. Binns,
Publicity Chairman.

RESOLUTION

WHEREAS, all all-wise providence has seen fit to remove from our midst, Dr. John E. Cuning, who was our valued co-worker and a faithful member of the Pulaski County Medical Society, since January 3, 1949, we the members of the society mourn and deeply regret his sudden departure.

WHEREAS, as a physician in his chosen field of psychiatry he attained a great measure of distinction and won the respect of his colleagues, as well as, the gratitude and love of a host of sorrowing people.

THEREFORE, BE IT RESOLVED, that the Pulaski County Medical Society express to his family the esteem in which he was held as a member of the Society and its heartfelt sympathy to the family at the untimely loss that they have sustained.

BE IT FURTHER RESOLVED, that a copy of this resolution be made a matter of record in the minutes of this meeting; that a copy be sent to the family and a copy sent to the Journal of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Pulaski County Medical Society by your committee:

George W. Jackson,
Oscar Kozberg,
H. C. Miles.



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CORRESPONDENCE

February 20, 1950.

Pulaski County Medical Society,
1439 Donaghey Building,
Little Rock, Arkansas.

ATT: G. G. Fulmer, Executive
Secretary-Treasurer

Dear Mr. Fulmer:

Enclosed herewith is my personal check in the amount of \$25.00 as payment of my 1950 American Medical Association annual dues.

Although I am in full-time preventive medicine and receive a very nominal annual salary for my services, it is my sincere feeling that all licensed physicians within the state of Arkansas should consider it a personal privilege to pay this very reasonable and justifiable \$25.00 dues when all the facts are considered.

Those of us who are devoting our full time to preventive medicine, public health, educational efforts and other institutional work are not favored by the much larger annual incomes that most of our colleagues engaged in the private practice of curative medicine receive. We all possess the same professional background and affiliations. Basically all of us strive to better serve the public and humanity. Because of these facts we should all strive to sincerely further elevate our profession and combat any socialistic trends or forces.

When one realizes and eventually appreciates the efforts that the American Medical Association is making to combat socialized medicine, compulsory health insurance, federally controlled medicine, etc., I again state that we should consider it a personal privilege to pay the \$25.00 annual dues as has been requested by the AMA. Should any appreciable percent of the members of our profession fail to pay this annual dues to the AMA, they will be automatically dropped from the American Medical Association register. Should the AMA then be required at the end of the year 1950 to report that several thousand members of the Association had been dropped from the register for failure to pay dues, the medical profession would then be playing directly into the hands of the socialistic thinking groups of our government and country. Mr. Oscar Ewing and his group could then justifiably state that thousands of licensed, recognized physicians did not see eye to eye with the American Medical Association in its efforts to prevent

socialized medicine or compulsory health insurance. Frankly, this would be the very best point of argument for the Ewing group that could possibly be brought about.

It is my sincere personal opinion that any member of our Society who has not paid or who is reluctant to pay the \$25.00 dues should think seriously of the damaging possibilities that might occur should thousands of other physicians feel as he does.

Yours very truly,

EDGAR J. EASLEY, M.D.,
President-elect.

—◆—
INTO HIS OWN

(Relayed by A. S. J. Clarke, M. D.)

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—Journal of the American Medical Association, March 25, 1950.

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ROY CARL YOUNG, M.D., Psychiatry and Neurology

A. LAURIE YOUNG, Manager

The Protein-Rich Breakfast and Morning Stamina

Extensive studies* by the Bureau of Human Nutrition have established that breakfasts rich in protein and supplying 500 to 700 calories, effectively promote a sense of well-being, ward off fatigue, and sustain blood sugar levels at normal values for the entire morning postbreakfast period.

These physiologic advantages are related mainly to the protein content rather than to the caloric content of the breakfast. In fact, when isocaloric breakfasts were compared, those with the higher amounts of protein led to the greatest beneficial effects. Breakfasts providing the lower quantities of protein (7 Gm., 9 Gm., 16 Gm., and 17 Gm. respectively) produced a rapid rise in the blood sugar level and a return to normal during the next three hours. Breakfasts providing more protein (22 Gm. and 25 Gm. respectively) produced a maximal blood sugar rise which was lower than that following the breakfasts of lower protein content, but the return to normal was delayed beyond the three hour period.

The subjects on the higher protein breakfasts "reported a prolonged sense of well-being and satisfaction." The findings indicated that the beneficial effects of the high protein breakfast on the blood sugar level may extend into the afternoon.

Meat, man's preferred protein food, is a particularly desirable means of increasing the protein contribution of breakfast. The many breakfast meats available are not only temptingly delicious and add measurably to the gustatory appeal and variety of the morning meal, but they also provide biologically complete protein, B-complex vitamins, and essential minerals. *Meat for breakfast, a time-honored American custom, is sound nutritional practice.*

*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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THE PRACTITIONER'S PROBLEM IN EVALUATING THORACIC CASES IN LIGHT OF MODERN ANTI- BIOTIC THERAPY*

J. K. DONALDSON, M. D.

Little Rock

No more than six years ago, many authors especially interested in thoracic surgery were offering a rather sweeping indictment against the general practitioner and internist for not following a "few simple rules of diagnosis" and referring patients with cancer of lung, for example, to the thoracic surgeon earlier.

In retrospect, it must be acknowledged that the general practitioner has done a pretty good job in adjusting himself to the possibilities of modern thoracic surgery; in following rules of diagnosis and referral which were previously suggested to him by those especially interested in thoracic problems.

And ironically it would seem that now possibly, the thoracic surgeon is not in as secure position to be critical and ultra-dogmatic as he was six years ago.

Six years ago the problem of diagnosis and treatment of surgical disorders of the chest seemed and actually was less complex than it is today.

For one thing, we formerly believed that at least 75 per cent (some said 90 per cent) of carcinomata of lung were situated in or near the main-stem bronchus where they could be seen and diagnosed by the simple expedient of bronchoscopy. We now know that 50 per cent, probably more, of primary carcinomata of lung are situated too far distant to be seen through the bronchoscope. This fact within itself actually has thus almost doubled the difficulty of easy,

early, diagnosis of carcinoma of lung over that of our conceptions of diagnosis of six to ten years ago.

Secondly, the more modern antibiotics as penicillin became available for general usage during the past six years. And antibiotics have done two things which have appreciably complicated exacting diagnosis of thoracic disorders in general, especially disorders of lung:

1. They have in general altered completely the pathologic pictures of previously classical pyogenic infection of lung and pleural cavity. For example, it is rare indeed that we now see abscess of lung and empyema in the forms which were quite common before the days of antibiotic therapy.

As a consequence it is now often difficult for one to differentiate ordinary pyogenic pathology in lung altered by antibiotics, from that pathology caused by fungous infections, or from pathology of tularemia, tuberculosis and Friedlander's infection, for example; to decide whether a given infection is primary, or secondary to a tumor or a cyst of lung.

2. Secondly, modern antibiotics will often cure some infectious disorders of lung which were previously usually surgical, for example some early ordinary pyogenic abscesses, actinomycosis of lung; and some other infections.

Another factor which has complicated our diagnostic field during the past six years has been necessity for attempt to evaluate usage of the Papanicolaou smear for diagnosis of carcinoma of lung.

To reiterate to some extent, but to summarize, the foregoing facts simply add up to the following:

(1) General practitioner and thoracic surgeon alike are actually confronted with more complex diagnostic problems regarding potential surgical disorders of the chest than they were less than six years ago.

(2) We must be careful not to operate cases which can be cured by modern antibiotics; and at the same time not allow usage of antibiotics

*Read before the 73rd Annual Session, Arkansas Medical Society, Little Rock, Arkansas, April 15, 1949.

My thanks are due Sister Teresa and the girls in the record room at St. Vincent's Infirmary for their kindness in assisting me regarding the records in some of the cases reviewed.

to mask surgical disorders, as for example, carcinoma of lung, until hope for cure is past.

One objective of this paper is to offer a set of arbitrary diagnostic rules, or a diagnostic routine, which the speaker believes should be followed fairly closely at this time whenever practicable. Before this is done, however, a few case reports will be presented to illustrate some of the points discussed above.

The cases presented are selected from 508 applicable ones seen in consultation or operated during the past two years.

I am indebted and grateful to many of you present for referring me, or working with me in one way or another on many of these cases. If one of your cases has not been selected for presentation it does not mean, of course, that I am less appreciative to you.

Chronic Surgical Interstitial Pneumonitis Following Lobar Pneumonia Treated with Antibiotics and Chemotherapy

Case 1: J. C. M. This white male, aged 63 years, became ill suddenly about four months preceding our observation of him with cough, pain in chest, and temperature of 103 degrees. His capable family physician promptly recognized all the classical signs of onset of lobar pneumonia, placed the patient in the hospital and administered ample dosage of penicillin and a sulfonamide.

The patient responded promptly to treatment, but remained in bed about nine days.

After becoming ambulatory he continued to expectorate one to two cupfuls of purulent odoriferous sputum per day and failed to gain weight and strength properly.

In four or five weeks he again was seized with abnormally high temperature, reported back to his family physician and was hospitalized. He was given a proper course of antibiotic therapy.

Temperature subsided to normal within a few days, and though some abnormal cloudiness remained in the right lung the family physician hoped that resolution would occur with sulfonamide therapy which the patient continued at his home.

Five or six weeks later he returned to the family physician again with onset of high temperature and cough with continued expectoration of purulent sputum.

The family physician did bronchographic study.

Slide 1: No bronchiectasis nor cavitation were demonstrable. The shadows that you see in the slide are a marked cloudiness and opacity in the lower part of the right pulmonary field, P-A plate.

The family physician concluded that permanent damage, a chronic interstitial surgical pneumonitis had occurred as sequela to this patient's lobar pneumonia.

The above case illustrates several important points:

1. The typical sudden onset of lobar pneumonia was sufficiently characteristic to enable this patient's physician to recognize that in all probability he was dealing with lobar pneumonia; that an atypical pneumonia, or pneumonitis secondary

to a tumor or cyst of lung was probably not present. (Such clear-cut conclusions are often not obtainable in the differential diagnosis of a pneumonitis.)

2. Proper chemo- and antibiotic therapy were administered promptly after the patient reported to his family physician. Nevertheless, a residual chronic surgical interstitial pneumonitis remained as a sequela of the pneumonia.

This latter pathology was recognized and after proper trial at conservative treatment surgical excision of irrevocably damaged parenchyma of lung was recommended; and unduly prolonged morbidity and possible secondary complications of serious nature as more extensive involvement of lung bronchiectasis, secondary empyema, osteomyelitis, abscess of brain, were prevented by relatively early surgery.

3. In the days before modern chemo- and antibiotic therapy, this patient with a virulent infection probably would have died. If not, a "classical" empyema, possibly a well-encapsulated previously classical type of abscess of lung would probably have occurred.

4. The pathology of the chronic interstitial pneumonitis secondary to lobar pneumonia in this case could not be differentiated roentgenographically from pneumonitis from many other causes as discussed later in this presentation.

A Case of Reoccurring Almost Fatal Pulmonary Hemorrhage Following Lobular Pneumonia Properly Treated with Penicillin and Chemotherapy

Case 2: M. P. This white female, aged 55 years, was seized in August, 1947 (without previously relevant history), rather suddenly with abnormally high temperature, cough and physical findings which caused her family physician to believe that she had ordinary lobular pneumonia. We believe this was the correct diagnosis.

The patient was hospitalized and treated properly and promptly with penicillin and sulfonamides by the family physician.

Response and progress seemed normal and uneventful for several days. Then the patient suddenly began to expectorate blood.

In brief, hemorrhage from lung became severe and reoccurring.

The family physician gave the patient multiple transfusions (eight in ten days) before he could bring the patient in satisfactory condition for transportation to us for further treatment. Even then, when the patient reached us, she presented obvious signs of severe loss of blood.

Slide 2: The remarkably minimal abnormal roentgenographic pulmonary finding in this case are presented in the slide. One will see in the slide that the only relevant abnormal roentgenographic manifestation is slightly abnormal increase in opacity in a quite limited area in the mesial part of lower right pulmonary field (P-A plate).

In view of the paucity of roentgenographic findings we were concerned with the possibility that we might carry out surgical intervention upon the wrong side in this case.

We bronchoscoped the patient and noted some fresh blood coming from the right middle lobe of the lung. This gave us more assurance as to proper surgical approach.

On September 5, 1947, we operated the patient at St. Vincent's Infirmary. Gross findings were minimal and not very obvious.

In the anterior mesial aspect of the right middle lobe of the lung moderate thickening of pulmonary tissue over an area of approximately 3x3 cms., was present.

Resection of this area revealed a soft-walled seemingly non-infected cavity approximately $1\frac{1}{2} \times 1\frac{1}{2}$ cms. in dimension. Erosion of a relatively small artery had occurred in this cavity.

Slide 3: The patient made an essentially uneventful convalescence.

A Case of Actinomycosis of Lung in Which Unnecessary Surgery Was Almost Performed Because of Confusion Regarding Diagnosis

The author has seen in two years, in this series of 508 cases, five cases of actinomycosis; roughly, of course, an incidence of 1 to 100. This incidence is not high. But, it is sufficient to be of importance. This is especially true since actinomycosis now is usually amenable to antibiotic therapy; since a serious surgical mistake could be made if the condition were not recognized.

Case 3: D. B. This white male, aged 27 years, was seen by his family physician two or three months previous to referral to us. The patient was suffering from a low-grade pneumonitis, low-grade elevation of temperature, moderate expectoration of moderately odoriferous type, and loss of weight. Symptoms in general could not be differentiated from those of pulmonary tuberculosis nor from those of a low-grade chronic residual pneumonitis which might have followed an ordinary lobar or lobular pneumonia which had been attenuated by antibiotic therapy.

Slide 4: The slide reveals pathology in the right upper lobe which cannot be differentiated roentgenographically from that of pulmonary tuberculosis and a number of other disorders.

Bronchoscopic examination was grossly negative excepting for some purulent material noted from the right bronchi.

The referring physician had had several specimens of sputum studies for tubercle bacilli, with negative results.

We studied secretions aspirated through the bronchoscope for tumor cells by Papanicolaou smear, for fungi, and other microorganisms including tubercle bacilli. After this, and five or six studies of different specimens of sputum for fungi and other relevant microorganisms were "negative" we concluded that chronic pneumonitis of undetermined origin was present and that lobectomy was indicated.

We scheduled for lobectomy. Then the day before the operation was to be performed, a bacteriologist was finally able to demonstrate "actinomycetes" in the sputum. Operation was cancelled and the patient was placed on penicillin and sulfadiazine therapy.

Slide 5: The patient responded favorably. Note marked clearing of the pulmonary pathology in comparison with the previous slide.

As indicated by the response of this and others

of our cases as well as by reports of other authors, we must conclude that actinomycosis of lung will respond in most instances to proper antibiotic therapy.

At present we believe that 100,000 units of penicillin intramuscularly every three hours (adult dosage) for ten days will arrest or cure most cases, even many far advanced. We have no experience as yet with attempting to maintain proper levels in blood with other than ordinary penicillin in actinomycosis, nor have we tried oral dosages of penicillin for actinomycosis.

A Case of Friedlander's Infection of Lung

Case 4: M. C. This patient, a not particularly co-operative one, was observed and treated by a very capable family physician over a period of three or four months previous to referral to us.

Reoccurring flare-ups of high temperature, cough, relatively profuse "sticky," heavy, relatively non-odoriferous expectoration had been controlled to some extent by penicillin therapy and sulfonamides.

Slide 6: Illustrates the extensive pulmonary pathology present when the patient came under our observation.

Bacteriologic studies of sputum revealed the presence of Friedlander's bacilli in large quantities.

Streptomycin therapy was instituted as soon as the diagnosis of Friedlander's infection was made.

The patient made a dramatic response. His temperature dropped from 105 degrees to about 100 degrees within twenty-four hours.

After six days in St. Vincent's Infirmary the patient insisted on going home. His temperature was normal and expectoration had ceased. He had felt better than he had since onset of his illness several months previous.

The patient was referred back to his family physician.

The patient, as we understand it, became irritated because he had to wait thirty minutes a few days after his discharge from the hospital for the family physician to take a follow-up roentgenogram, and changed physicians.

Follow-up of the case has not been satisfactory, but it is our understanding that at a later date the patient had some reoccurrence of his symptoms. The patient also had sili-cosis.

Friedlander's infection can be cured by proper usage of streptomycin in most cases. Other antibiotics may prove to be effective.

The condition, though relatively unusual, does occur. It certainly should not be confused with primarily surgical infections of lung.

An Empyematous Pocket Sterilized by Antibiotic Therapy, Causing Confusion in Diagnosis

Case 5: Mr. C. This white male, aged 50 years, without previously relevant positive history became rather acutely ill May 2, 1948.

The family physician believed the patient had an ordinary primary pneumonia and treated the patient with penicillin and with follow-up sulfonamides by mouth.

The physician, for reasons with which we are not concerned here, was unable to keep this patient under close observation.

The patient's acute symptoms subsided quite promptly, and the patient became ambulatory and returned to work as a nightwatchman.

The patient continued sulfonamide therapy more or less at his own discretion.

In a few weeks he realized he had not gained strength nor weight satisfactorily and reported back to his physician. The patient's temperature in the afternoon was then almost within normal limits, i. e., 99-99½ degrees.

The physician promptly had a roentgenogram of the chest made when the patient returned.

Slide 7: This slide of the roentgenogram shows a rather circumscribed abnormal opacity in the left lower part of the chest, about 6x6 cms. in dimension.

One could not tell for certainty from this roentgenogram whether a tumor or cyst existed, or whether an old empyema was present.

We operated the patient at St. Vincent's Infirmary August 3, 1948, and found an empyema. We could find no evidence of neoplastic tissue in the depths of the cavity; and this together with other aspects of the case convinced us that this was a case of empyema secondary to an ordinary pneumonia.

Odoriferous pus was present, but had become for practical purposes sterilized and, therefore, the patient was not running acute symptoms.

Absorption of some toxin was occurring, lack of gain in weight and some malaise had been present, though these manifestations had not been nearly as severe as they would have been had not antibiotic therapy been used.

The principal point of the case is that an empyema may become sterilized or attenuated by modern antibiotic therapy to extent that though complete recovery of the patient does not occur the patient's symptoms may be of "low-grade" character; and confusion may arise as to the true nature of the disorder.

Cases in Which Antibiotic Therapy Masks or Confuses Diagnosis of Tumor of Lung

This group of cases is of great importance.

Most of those cases presented above have illustrated ones in which primary infectious disorders of one nature or another, were relatively obvious.

In the first case reviewed in the previous part of this presentation, the capable family physician by eliciting carefully the patient's history was able, for example, to conclude with relative sureness that a typical lobar pneumonia was present. And in other cases previously presented it seemed obvious in most instances that one could by careful analysis and history be reasonably sure that no tumor was present. However, to elaborate further upon some of the opening remarks, we are now seriously confronted with the fact that antibiotic therapy, easily available and easily administered, is often demanded by the public unwarrantedly for even such things as ordinary colds and for most every other manifestation of upper respiratory infection.

Practicalities of the everyday pursuit of our profession have sometimes demanded a wide and

sometimes almost promiscuous usage of antibiotics or chemo-therapy.

For example, Mr. X, a friend with limited means, comes in from the farm without appointment to the busy practitioner's office.

The patient states that he has had a "fever" for the last two or three days, a little cough, possibly a "chill."

He hasn't noticed any particular trouble before excepting maybe "a little cigarette cough."

None of the classical history of advanced carcinoma of lung are present. His early manifestations on basis of a rapidly taken brief history cannot be differentiated from those of current upper respiratory infections perhaps.

Mr. X may request the physician to give him a shot of penicillin. The shot of 300,000 units of penicillin is given and the patient feels considerably better.

The physician may warn Mr. X very explicitly that the latter should return within the next few days for further study. But the patient, feeling better, may disregard the advice and return two months or later after further symptoms have developed.

After the patient returns in two months with a little increase in his cough, possibly a "little" expectoration of blood, he has concluded perhaps that he has pulmonary tuberculosis—so informs the physician and requests that he be sent to a sanatorium for tuberculosis.

Too often from the standpoint of practicality, the physician may send Mr. X to a sanatorium for tuberculosis without making further studies himself.

In the process of waiting for admittance and undergoing necessary observation after admittance, valuable additional time may be lost before the patient is discharged from the institution when the diagnosis of tuberculosis is not confirmed.

The above mentioned are some of the practicalities which confront the general practitioner every day. Yet, we know that because of these problems lives are lost daily; that earlier diagnosis of malignancy of lung would save many lives.

(We know the high incidence of malignancy in general; that one out of about every eight patients suffering from malignancy, have malignancy of the lung. Carcinoma of lung is about the second or third leading site of cancer in men and women respectively.)

The following case illustrates the problem of

diagnosis with which you and I are confronted in dealing with possible carcinoma of lung:

Case 6: C. B. This white male, aged 51 years, noticed one day in October, 1948, that he had some cough, a "little temperature, a little aching of his bones." He felt, he said, as if he might be taking the "flu." He wished to believe his cough was no worse than the "cigarette cough" which he had "had for years."

He reported to a well qualified physician. The latter gave him 300,000 units of penicillin.

The patient returned to his work with, he believed, disappearance of symptoms.

About one month after first onset of symptoms he noticed "a little pain" in the sternal region of the chest. This slight discomfort was not considered of consequence by the patient.

In December of 1948 (about two months after onset of symptoms sufficient to cause him to report the first time to his physician) symptoms similar to those of the first episode occurred; and he reported to a different physician.

Penicillin was again administered, but the physician insisted that roentgenogram of chest be made.

In January, 1949 (now about four and one-half months after onset of symptoms) the patient did obtain the roentgenogram and reported back to his original physician.

The physician after reviewing the plate, promptly referred the patient elsewhere for a careful work-up believing that the patient might have tumor of lung. This impression was quickly confirmed by a diagnostician well qualified regarding thoracic problems, and the patient was then referred to us for additional studies and disposition.

I bronchoscoped the patient March 1, 1949, and collected aspirated material for bacteriologic studies for Papanicolaou smear.

The results of the bacteriologic studies were all "negative," including a search for fungi, and no tumor cells were found on Papanicolaou smear.

The patient was having some slight dyspnea on moderate exertion. Vital capacity was near the legitimate borderline of "safe" operability for a major pulmonary disorder.

Slide 8: One sees in this slide of the roentgenogram of the chest a "thickening," a relatively small abnormal shadow, about the left hilus, which is not diagnostic. In this case there is no evidence of pneumonitis distal to a tumor as one so frequently sees.

In brief, however, considering all aspects of this case, we concluded that unresectable malignancy was probably present in this patient despite "negative" findings at bronchoscopy and "negative" report regarding the Papanicolaou smear.

We informed the family that we considered the patient had less than one chance out of ten of having a successful eradication of the malignancy we believed to be present. They elected to have the operative procedure performed, nevertheless, in order to settle the diagnosis definitely; to give the patient any even slight opportunity which might exist for cure or reasonable palliation.

Exploratory thoracotomy was performed under local anesthesia, March 3, 1949, at St. Vincent's Infirmary.

An advanced unresectable malignancy of lung was found. "Caking" of neoplastic tissue extended upward from the hilus along mediastinal pleura to the apex of the left hemithorax and into the mediastinum along hilar structures.

The patient recovered satisfactorily from the operative

procedure and was sent home in a few days; though, of course, he was not actually benefited by the operation.

If the time permitted we could offer several other cases illustrating the treacherous nature of carcinoma of lung and other intrathoracic tumors; the manner in which antibiotic therapy, controlling pneumonitis secondary to a tumor may confuse the patient and the physician while the tumor progresses. Actually, however, the case just presented is sufficient to illustrate this point without laboring further in this series regarding cases which have been successfully and unsuccessfully operated.

Comments

Possibly some of whatever value might have been offered in this presentation may have been lost as the paper is offered in the Journal, since the roentgenograms presented in the slides have not been reproduced here.

Yet, the principal objective of the lantern slides was to show that there are no consistent roentgenographic findings which enable the roentgenologist or others to make a uniformly reliable specific diagnosis between many primary infectious disorders of lung and infections of lung which are secondary to early carcinoma. By keeping this in mind as the paper is reviewed, context may seem less unsatisfactory.

Diagnostic Working Rules which have not been discussed at length in the body of the paper are offered in "Conclusions" below.

Conclusions

I. Modern antibiotic therapy, widely and frequently used for pneumonitis, often attenuates a pneumonitis secondary to a tumor in lung or elsewhere in the chest; and thereby often confuses the patient and sometimes the physician while the tumor progresses and becomes inoperable.

II. The Papanicolaou smear is definitely of great value in diagnosing carcinoma of the lung. However, the technicalities attendant with its procurement and upon its interpretation must be appreciated fully else one or two laboratory reports regarding it may be misleading. (See "Diagnostic Working Rules" below.)

III. The thoracic surgeon and practitioners in general must realize that modern antibiotic therapy now will cure some infections of lung which were previously surgical. An outstanding example is that of actinomycosis of lung which is not uncommon as we previously believed.

We are, therefore, confronted with the neces-

sity for very meticulous bacteriologic studies in many cases which cannot be differentiated clinically and roentgenographically from surgical conditions if we are to avoid unnecessary thoracic surgery.

IV. We believe that at the present one should adopt as a working plan the general diagnostic working rules presented here. These rules will not apply in all cases and must be varied according to practicalities and sound judgment; but are considered as a safe foundation for diagnostic procedure.

Diagnostic Working Rules

1. Take roentgenograms promptly in cases suspected of having thoracic pathology, but remember that carcinoma of lung cannot often be diagnosed in its early stages by roentgenograms.

2. Bronchoscope the patient suspected of possibly having a tumor of lung promptly, obtaining biopsy or secretions for microscopic study; but remember that no more than fifty per cent reliance may be placed in bronchoscopy alone for diagnosis of cancer of lung.

3. Since primary pneumonitis has varied etiology which is sometimes difficult to demonstrate, i. e., actinomycosis, other fungi, Friedlander's bacilli, etc., multiple examinations of multiple specimens of sputum may be indicated. Furthermore, in doubtful cases multiple specimens of sputum should be examined by Papanicolaou smear for tumor cells. Therefore, in many cases where the true nature of intrapulmonary pathology cannot be clarified by simpler means:

- (a) Procure daily specimens of sputum for seven to fourteen days for study regarding tubercle bacilli (to extent indicated), fungi or other relevant microorganisms, for tumor cells by Papanicolaou smear.

- (b) Repeat the studies just mentioned in thirty days in indicated cases.

- (c) In some instances agglutination tests as for tularemia and complement-fixations tests for other disorders may assist in diagnosing a confusing intrathoracic infection.

4. Some cases should be explored promptly regardless of all negative findings.

5. Thoracotomy under local anesthesia, as discussed by the author at the Meeting, will lower operative mortality of exploratory thoracotomy and, therefore, broaden applicability of the procedure if proper care is used in selection of cases.

CHORIOEPITHELIOMA

JACK WRIGHT, M. D.

Hot Springs National Park

Chorioepithelioma is a tumor of very varying malignancy of the epithelial tissue of the chorionic villi. It is often spoken of, not often seen, but a condition that must always be kept in mind if a surgeon or physician practices any gynecology or gynecological surgery. It occurs most often after the passage of a hydatidiform mole, an abortion, or normal childbirth. It has also been reported in a six-year-old virgin, during normal pregnancies, and twenty-five years post-menopausal.

The clinical condition has been known for years. However, Sanger was the first to write accurately about the condition about 1888 to 1893. Williams reported several cases around 1895, but while he recognized that the tumor was of epithelial origin instead of sarcoma as Sanger thought, he thought that the tumor originated from the tissue of the host. Credit is given to Marchand in 1895 for recognizing that the tumor originated from the chorionic epithelium and therefore from a foreign subject. This may explain some of the bizarre clinical results with these tumors.

The tumor is not a rare one although very few people have reported large series of cases. Curtis in his "Operative Gynecology" reports having personal experience with only seven cases and four of them were on the autopsy table. Jeffrys and Graffignino report fourteen cases in thirteen years at the clinic at Charity Hospital in New Orleans. Pelyon Tew reports four cases in ten years. We have had four cases at Northwest Clinic in the past six years.

Chorioepithelioma occurs usually in the child-bearing age after the passage of a hydatidiform mole, an abortion, or a childbirth. The percentage of incidence increases with the number of pregnancies in any given individual—being much more common in multiparae. There is a variable period between the anteceding pregnancy and the appearance of the tumor from a few days to a few years, but the average is one to four months. Dorr and Cutler reported a case twenty-five years after the menopause and Kroeising reported a case at 58 years of age, six years after the passage of a hydatidiform mole.

The malignancy has been reported as following the previously mentioned cases by several ob-

servers. The percentages are usually similar to those reported in Figure 1.

FIGURE 1

Conditions Antecedent	Appearance of	Chorioepithelioma
	Teacher	Pollasson & Violet
Hydatidiform mole	36.6%	44%
Abortion	31	30
Pregnancy at Term	28	22
Extrauterine	04.4	4

The malignancy is a luxuriantly growing proliferation of the trophoblastic epithelium of syncytium and langhans cells. There is invasion of the uterine wall and venous sinuses to a marked degree which accounts for the high percentage of very early venous metastases. The organs most invaded are the lungs (75 per cent), vagina (54 per cent), brain (5 per cent), broad ligament, and vulva. As typical of normal chorionic tissue there is a formation of ferments with lysis of the invaded tissue. There is marked tendency to necrosis and ulceration due to the poor development of its blood supply.

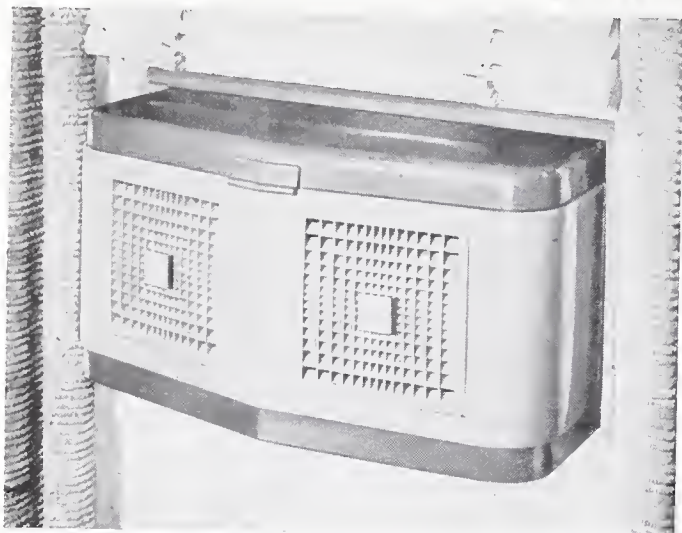
Marchang divided the chorioepitheliomas into typical and atypical groups. The late Dr. Ewing was one of the first to divide the tumors on a more definite basis. He made three classifications on the histological picture: (1) Chorioadenoma destruens. (2) Choriocarcinoma. (3) Syncytial endometritis or syncytioma. Chorioadenoma is characterized by elongated, hypertrophic villi surrounded by proliferated syncytium and langhans cells. There is a definite invasion of the uterine wall but metastases are relatively late. In choriocarcinoma there is marked proliferation of trophoblastic epithelium and the villus-like structure is entirely lost. There is overwhelming invasion of the surrounding tissue and venous sinuses and the prognosis is very poor. Syncytioma is a tumor composed of syncytial cells which are locally invasive but metastasize rarely.

Many pathologists state that definite histological classification is difficult because various sections through the same tumor would lead to different diagnoses. Sometimes it is necessary for several sections to differentiate benign lesions from early malignancy but generally Ewing's classification is used. Dr. Novak divides chorionic malignancy into: (1) Malignant hydatidiform mole (corresponds to chorioadenoma). (2) Chorioepithelioma malignum (corresponds to choriocarcinoma). (3) Syncytial endometritis, which he really believes is no neoplasm at all but syncytial cells which have invaded the uterine wall and are usually associated with a low-grade infection.

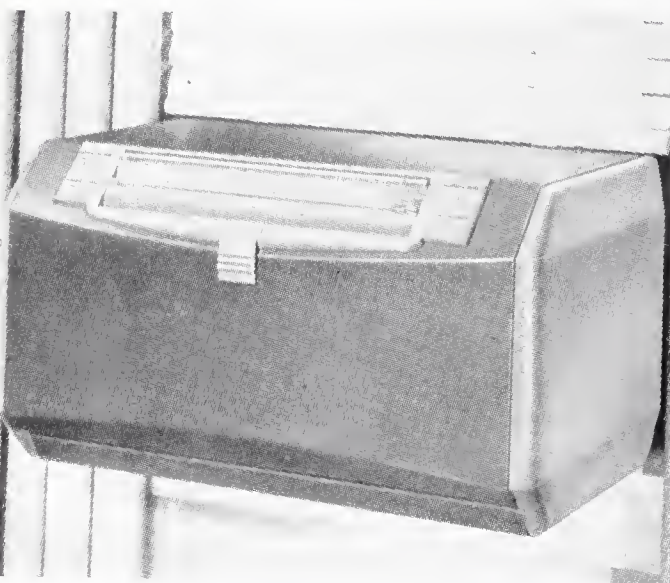
The usual site of the tumor is the placental site although it may occur at any area of the uterus

or as it frequently does, at more than one area. It may originate in the fallopian tube or ovary and in a small percentage of cases extragenitally. Many of the cases of extragenital origin which were first reported were probably metastases with complete or almost complete regression of the original tumor in the uterus. This was proven in many cases when the uterus was carefully examined. However, at least eight rather definite extragenital lesions have been reported recently. These are due to development of the trophoblastic tissue of teratomas to the exclusion of the other tissues or from embryonal rests of the urogenital fold. It is also possible that the chorionic villi which often metastasize during a normal pregnancy may survive and lie dormant and later become malignant.

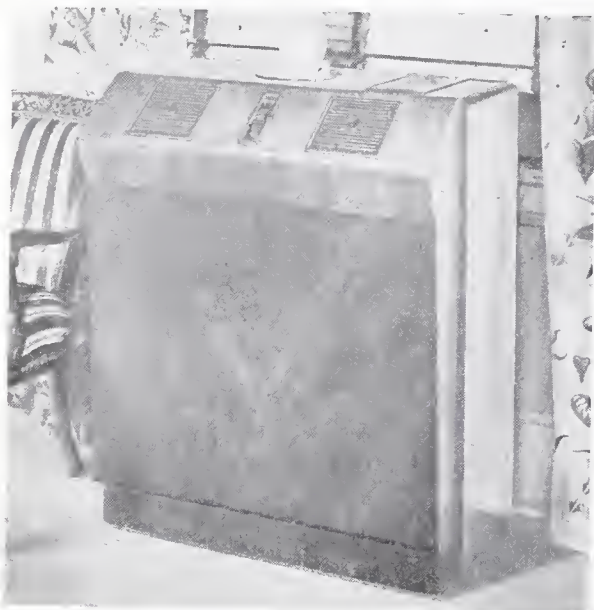
The symptoms are often quite dramatic. Usually there is history of a hydatidiform mole or an abortion or pregnancy. This is followed by an irregular bleeding. Due to the tendency to necrosis and ulcerations, bleeding is a marked symptom with resulting anemia. The patients may actually "bleed to death." The uterus is usually enlarged and boggy, more with the chorioadenoma than with the choriocarcinoma, and often bilateral ovarian cysts of the lutein variety are also present. In a number of cases pulmonary metastases are the cause of the first noticeable symptoms and highly colored nodules in the vaginal vault may be the first indication of a malignancy of the uterine area. The latter is due to the blockage of the usual uterine veins and a metastases retrograde through the collateral circulation. One of the most helpful signs of this condition is the marked increase in the gonadotropic hormone level. Living chorionic tissue produces anterior pituitary-like, gonadotropic hormone and this fact has been the basis of the Friedman and Ascheim-Zondek pregnancy tests. Normally 30 cc. of urine are injected into the vein of the rabbit in the Friedman test. If as little as 1/3 cc. of urine gives a positive test, one is led to believe that he is dealing with an abnormality of the chorionic tissue. For accurate quantitative tests, however, the Brindeau-Hinglais test using blood serum and immature female mice is the test of choice. The tests can be expressed in number of mouse units per liter of blood. In a normal pregnancy the level is between 5-15,000 units. In toxemias of pregnancy and hydatidiform mole the level often rises to 100,000 units. In chorioepithelioma the level often is above 200,000 units and such a level is very suggestive of a rapidly growing chorionic



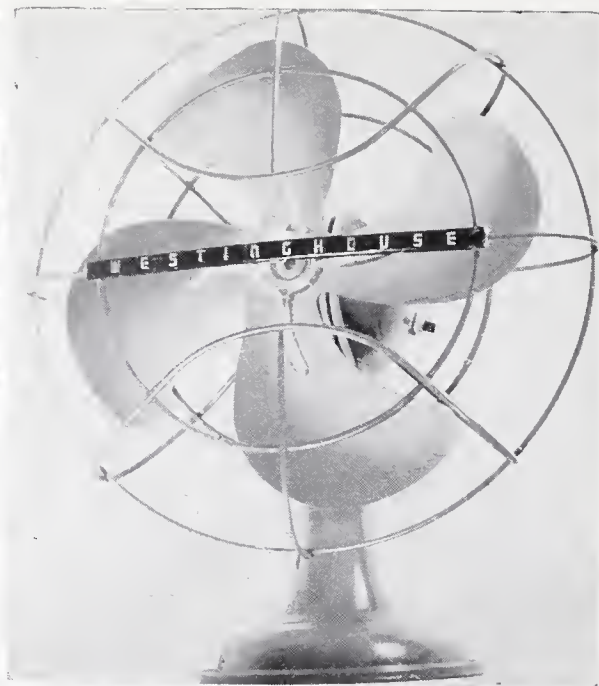
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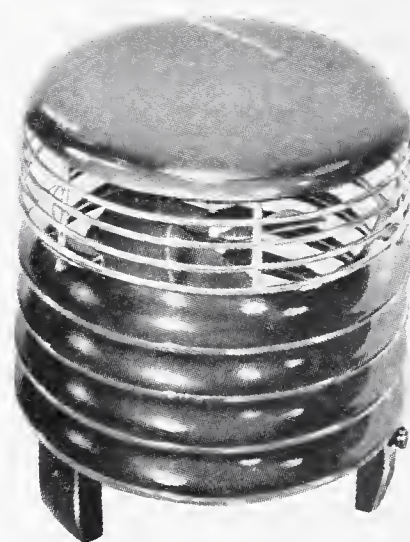
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tumor. In the higher levels, the spinal fluid is also found to give positive test and is quite suggestive, if present.

Even with all the tests, sometimes the diagnosis is not easy. The appearance of a hydatidiform mole must bring the possibility of a possible malignant development to mind. Though almost 50 per cent of the malignancies are preceded by a mole, it is estimated by many pathologists that only five per cent of moles do become malignant. The patients must be followed by monthly hormonal checks for a year and every few months for several years. If bleeding continues after a mole or an abortion, a diagnostic dilatation and curettage should be performed and many recommend curettage of the uterus after all early abortions and after the passage of a mole. However, much of the tissue obtained in a curettage is not diagnostic. The tissue is often only necrotic tissue or the tumor had burrowed into the wall of the uterus and is not reached by the curette. Diagnosis is not too hard in the definitely malignant and the definitely benign, but is often quite difficult in the intermediary groups. The pathologist is dealing with a tissue which normally has marked invasive characteristics with anaplasia of the cells and mitotic figures. Novak says that in many cases the diagnosis cannot be made until the uterus has been removed and the general invasive characteristics of the tumor observed. In many cases more than one D. and C. is necessary and if in doubt a vaginal hysterotomy should be performed. Then the uterine cavity can be explored with the finger or observed visually.

Also it has been shown that the biological tests are also far from conclusive. Many definitely proven cases of chorioepithelioma have given negative Freidman tests with tested rabbits. Many times urine of women with normal pregnancies will give positive test with very low amounts of urine. Two cases have been reported positive with as little as 0.07 cc. of urine. Another hazard has been pointed out by Dr. Payne of Philadelphia. He has shown that the Friedman test is positive from six days to ten months after the passage of a benign mole.

However, with these variations in mind we can surmise on general patterns. If on the following of the post mole and abortion stage, the gonadotropic hormone level gradually decreases for a time and then gradually begins to rise, then if another pregnancy can be ruled out, a growing chorionic tumor is likely.

The treatment of these tumors is surgical if at

all possible. The patients need blood preoperatively in most cases and if the tumor has not spread to distant organs as shown by symptoms and X-ray, a radical panhysterectomy is needed for the chorioadenoma and choriocarcinoma groups. In syncytial endometritis, many people, notably Novak, recommend more conservative treatment. Often a thorough dilatation and curettage is sufficient. Some pathologists and gynecologists recommend hysterectomy on the basis that the tissue is invasive and cases of definite perforation of the uterine wall has occurred with peritonitis and death.

With this group of tumors the prognosis is very variable. As stated, a thorough dilatation and curettage is often sufficient to cure most of the syncytial endometritis or syncytiomas. If chorioadenomas are removed moderately early with any vaginal nodules, the prognosis is usually good because of their slowness to metastasize. Choriocarcinoma is another picture indeed. The mortality is from 70-80 per cent. Dr. Ewing stated that he had never seen a case that was cured if diagnosed clinically. There is marked early metastases and often before any other symptoms. However, in a percentage of cases, Novak saying as much as 10 per cent of the cases, bizarre clinical results have been seen. Definitely proven cases of choriocarcinoma have been cured with an otherwise inadequate curettage of the uterine cavity. Many cures have been reported when there were definite vaginal nodules, removed with the hysterectomy. Many cases have been shown to spontaneously disappear from the uterus and even numerous distant metastases have disappeared suddenly without cause. At first this was thought to be due to the tendency of the tumor to ulcerate with the total destruction of the tumor. This is not held to be true at present. We do know that very often in a normal pregnancy there are definite embolic spread of living chorionic villi which live and grow in distant organs during pregnancy. These have been shown often in X-ray studies of the lungs. After the childbirth or before these areas are destroyed by the mother host. This may very well explain the miraculous cures of this very malignant tumor which happen at times. Another example of the unusual cures seen in this disease is the case reported by Maier and Taylor. They had a 33-year-old woman that reported with a growing tumor in her right lower lobe of the lung. She has passed a hydatidiform mole five months previously with twelve subsequent negative Ascheim-Zondek tests. The A-Z test

later became positive. The right lower lobe of the lung was removed with finding of choriocarcinoma. The uterus was later removed and was free of the tumor. The patient has had no further symptoms in the past four and a half years.

We have had four cases here in the last six years. They have all occurred after the passage of a hydatidiform mole. The fourth case was recently treated and is representative of the group. She was a 39-year-old woman in good health prior to the present illness. She has three children, 12, 6, and 3 years of age. She has had no major operation in the past. Her menses have been regular every 28-30 days for a period of 4-5 days. In July, 1947, her menses were scant. In August the bleeding period was normal. She had no bleeding in September and on October 25 she began having morning emesis. After about a week she began a slight irregular flowing. This continued despite corpus luteum extract and other medications given by the local physician. On November 11, 1947, she had a D. & C. and material of a hydatidiform mole was removed. She continued to bleed and soon another D. & C. was performed. Three weeks later another D. & C. was performed by the local physician and when the patient continued to bleed she was referred to the Northwest Clinic. On admission the patient was very anemic. Her hgb was 50 per cent and she looked as if it were worse. There was a complication in that she was a type 3, Rh negative. She was bleeding so that it was necessary to pack her uterus while we were getting her ready for surgery. She was given six transfusions. X-ray of the chest revealed no evidence of metastasis and Friedman test was positive. A radical pan-hysterectomy was performed and no evidence of spread of the tumor was found. The uterus was opened and two dark brown fungating lesions 1.5 cms. in diameter were found on the uterine wall with invasion of the wall. Later sections revealed they were chorioepithelioma. She was given more blood post-operatively and was discharged from the hospital in good general condition. The other cases were treated in a similar manner without mortality at this time.

"GRASSROOTS" OBLIGATION

" . . . The A.M.A. cannot support or oppose candidates for public office. That is not the province of the A.M.A. or of State and County medical societies. But every doctor, in his own community, if he believes in sound medical practice, and if he believes in maintaining American freedom, not only has the right to support candidates who square with his convictions but he has a sacred obligation to do so."

This exhortation, from the report of the Coordinating Committee of the A.M.A. given at the December, 1949, meeting in Washington, should be heeded by every physician. He should find out, before casting his ballot, how every candidate for public office stands on the President's socialized medicine proposal. And if he should get his patients to do likewise, candidates will understand, unmistakably, the sentiments of the voters.—Norfolk Medical News, March 1950.

CORRESPONDENCE

Headquarters Army and Navy General Hospital
Hot Springs National Park, Arkansas

20 April 1950.

Doctor W. R. Brooksher,
Secretary, Arkansas Medical Association,

Fort Smith, Arkansas.

Dear Doctor Brooksher:

This hospital faces a very critical shortage of medical officers during the next 60 to 90 days. The Office of The Surgeon General, Department of the Army, informs us that they have a number of officers now in training who will be available for assignment here in August but they offer us very little hope of any assistance until then.

Funds are available for Reserve officers to spend up to thirty days on active duty training here. Such tours by Reserve officers, if we can secure them, will serve to tide us over this very critical period. We particularly need a qualified officer to act temporarily as chief of the genito-urinary section and an officer for our EENT section during the month of June. We could likewise use the services of several officers in a general medical duty capacity. Officers interested in this duty can procure any information needed from their immediate Reserve headquarters. In addition I would be very glad to assist them in any way possible.

Any assistance you can give us in this matter will be greatly appreciated.

Sincerely,
Roary A. Murchison,
Colonel, M.C.,
Commanding.

April 20, 1950.

Dear Mr. Wrightsman:

The Fifty Year Club met for the first time April 18th since receiving the name and pins in 1949. At the breakfast hour Dr. J. O. Rush, of Forrest City, was chosen chairman and myself secretary of the club. As you know, this club is composed of doctors who have been in practice 50 years or more and is made up of geriatrics who are prone to forget to pull up their zippers, hence the majority forgot to attend. So in the future I will notify each member in advance of this meeting.

Sincerely,
J. H. McCurry, M. D.

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EDITORIAL

A ONE-SENTENCE EDITORIAL

Administration is no problem to government: there is one employee in the Indian Service for every 32 Indians.

THE ANNUAL SESSION

316 members registered at the 74th annual session held in Fort Smith April 17-19th for a most successful meeting. The scientific program was excellent, the scientific exhibit space was filled, commercial exhibits were limited because of lack of space but a number of our faithful firms were on hand to extend greetings and the host society, Sebastian County, did itself proud with the social activities incident to the meeting.

In the House of Delegates action was taken on a number of matters: (1) Recommended inauguration of preceptor training for senior medical students at the University of Arkansas School of

Medicine; (2) establishment of a facility for the training of retarded children; (3) approved report of the hospital relations committee with provision for further study of medical services as now provided under Blue Cross plan; (4) opposed subsidization of medical education; (5) favored repeal of legislation providing for admissions to the University of Arkansas School of Medicine on a Congressional district basis; (6) disapproved plan to establish heart detection centers; (7) recommended revision of medical practice acts; (8) commended appointment of Aubrey D. Gates to staff of Rural Health Committee of the American Medical Association; (9) approved national survey of physicians' incomes; (10) made changes in councilor districts, and (11) made provision for office of vice-councilors by proposed amendment. The following were elected life members of the Society: E. C. Hunt, Ola; S. M. Graves, Clarksville; W. B. Gould, Glenwood; W. H. Toland, Nashville, and B. L. Bailey, Star City.

Officers elected are: President, Earle H. Hunt, Clarksville; President-elect, Chas. R. Henry, Little Rock; First Vice-president, Fred H. Krock, Fort Smith; Second Vice-president, Ross Fowler, Harrison; Third Vice-president, G. L. Hardgraves, Clarksville; Treasurer, Dan H. Autry, Little Rock; Secretary, W. R. Brooksher, Fort Smith; Delegate to the American Medical Association, W. R. Brooksher; Alternate to the American Medical Association, Jos. F. Shuffield, Little Rock; and the following Councilors: Second District, J. J. Monfort, Batesville; Fourth District, L. K. Hundley; Sixth District, R. C. Dickinson, Horatio; Eighth District, John W. Smith, Little Rock, and Tenth District, Fount Richardson. John H. Wilson was re-elected chairman of the Council. The Society will next meet in Little Rock.

RANDOM THOUGHTS OF THE SECRETARY

March 31st. With Hawkins as traveling companion to Eureka Springs for the diagnostic cancer clinic, conducted at the courthouse, the hospital being strangely unsuited and ill-equipped for such procedures, despite the expert advice of hospital consultants.

April 6th. Visiting the Benton County group with Richardson, viewing the excellent motion picture, "Kidney Function in Health," and at a late hour all the way back Highway 71, whose curves and pavement holes we well know, to home and bed.

April 8th. Returning with Fount Richardson's Confederate flag for the annual session, an idea of the President's, we run it up on our own flag pole causing inquiry and bewilderment aplenty and secession might not be without benefit, even though Van Zandt County, Texas, failed.

April 10th. Guest of the dentists tonight who are having a postgraduate course on cancer by telephone, an innovation, and a successful one, in teaching.

April 12th. Returning after long months to DeQueen for a diagnostic cancer clinic in the modern Dickinson Hospital, built with the needs of the community foremost, offering an answer to medical service in rural Arkansas counties: well-trained physicians practicing in properly-arranged hospitals whose equipment is adequate and without frills.

April 15th. Comes "Three H" Hundley, bubbling over with thoughts of the coming convention, talking of the day when she will be a "past-president," talk which fools us not in the least. For a little celebration to the Dining Car with the Foltzes, affording our sheltered and secluded Auxiliary president, almost intimate contact with a rugged night life as practiced in a town famed for its days of "Hell on the Border," reminiscences of which, murder excepted, return to us as the night's evils culminate in a final exit of the rollicking, swearing dame who cared naught for some of the people at adjoining tables.

April 16th. To the Academy of General Practice meeting where the papers are of interest and later to watch the exhibitors and the early arrivals renew acquaintance * * * tonight briefly with the brass of our fraternity, and on the way to town, having the pleasure of short conversations with those gathered at the Krocks to greet the Hollenbergs and the Shipp * * * sitting through a long evening as the Council debates and decides a multitude of problems, hoping that correct decisions may be in the majority. * * * Then to the jointly-shared but unrehearsed party by the Autrys and the Kumpurises where conversation is unlimited and the refreshments only slightly less so.

April 17th. The 74th annual session becomes a reality, perhaps amazing to Wrightsman who has toiled these many months for this day. * * * President Smith's project of flags and music, received with cold shoulders by the local group, converts the majority who decide it is quite the thing to run up the curtain in this manner * * * during the day meeting many of our colleagues * * * assisting Gilliam of Des Arc, for whose physical stamina we have the greatest respect, in his search for a room * * * pleased with the smooth operation of the registration desk * * * wondering as we do each year what method would insure reasonably prompt delivery of telephone calls, particularly to the local men * * * noting that H. T. Smith is not wearing his new shoes today * * * The enthusiastic Edna Jones is present and glad are we to see her at a medical meeting again. * * * Also come the Bud Copes, tarrying with the meeting en route to Blue Mountain for Wednesday fishing. * * * Gathered about in chairs are the perennials: Tate, McCurry, Lutterloh, C. W. Hall, Rush, McVay, as others more actively engage in the business of seeing the meeting: Fred Ferguson, Peacock, Dildy, Owens, Fowler, Leverett and many another. * * * At seven away to Foltzes for the first of our appearances at cocktail parties scheduled for the evening * * * in rotation to the Holt-Krock clinic, the Koenig and the Cooper clinic parties, finding enjoyment and hilarity great throughout the evening, terminating a gala day by feeding late arrival Nell Branch hot dogs at the Cooper clinic and taking the Hundleys home.

April 18th. Rush and McCurry get out only four of their fifty-year clubbers * * * we almost miss a meeting and get proper ribbing from the radiologists especially since we were co-host * * * the Bill Dickinsons arrive on

PROCEEDINGS OF SOCIETIES

Craighead-Poinsett County Medical Society met at Jonesboro April 5th with the following scientific program: "Peripheral Vascular Diseases," Peter O. Thomas, Little Rock.

J. H. McCurry, Secretary.

The Arkansas Chapter, American Academy of General Practice, met at Fort Smith, April 16th, for the following program: "Infantile Paralysis," Barney P. Briggs, Little Rock; "Virus Disease of the Central Nervous System," John Adametz, Little Rock, and "Post-operative 'Pneumonia'," S. W. Hawkins, Fort Smith. The evening banquet session was addressed by J. P. Sanders, Shreveport. Officers elected are: President, L. H. McDaniel, Tyronza; President-Elect, M. D. McClain, Little Rock, and Secretary-Treasurer, Fount Richardson, Fayetteville.

The Benton County Medical Society met in a dinner session at Rogers April 6th. A motion picture, "Kidney Function in Health (Lilly)," was presented.

Lee A. Dean, Secretary.

The Pulaski County Medical Society was addressed April 3rd by Duane Carr, Memphis, on "Primary Tumors of the Lung."

the scene and Sevier County makes its presence known * * * the EENT section grows in numbers and extent, taking over for a full day and with over 30 in attendance * * * tonight for the banquet session where we take next to last place in the chow line * * * across the street to the dance where youth and age mingle on the floor and at the tables, particularly noting Mesdames Autry, Oates, McLochlin, Pinson, Reid, Woods, tripping light fantastic in its many styles * * * closing this session, too, and homeward to rest, grateful that we saw "Three H" through a happy and successful Auxiliary year but doubtful of her retirement.

April 19th. No secrets from the nominating committee this year, not a reversal of policy but realization that silence is maintained with utmost difficulty * * * again the reference committee demonstrates the monumental task which this duty entails prompting the House to provide for division of the labor at the 1951 session * * * Earle Hunt, veteran of 39 presidential installations, but only one like this, steps to the rostrum to receive the gavel and deserved applause * * * at the house for the post-mortem which is quite gay * * * dining with the Smiths and then leading them across town to wave farewell as they strike out on the highway for home, to begin living with the memories of 1949-1950: "when Al and Mike were president."

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

HISTORICALLY, tuberculosis has been a predominantly urban disease in the United States. Associated with poverty, congested housing, poor nutrition, and over-exertion, tuberculosis has taken its greatest tolls in the slums of the big city. The decline in the tuberculosis death rate since 1900 has been due in the main to urban developments among which are improvement in living standards and the isolation and treatment of cases in hospitals. In the meantime, what has been happening to tuberculosis in rural areas?

TUBERCULOSIS AND ITS CONTROL IN RURAL AREAS

Exact figures on tuberculosis in rural areas are not available. The recording of deaths in the United States before 1937 was by place of occurrence, not by place of residence. As hospitalization of the tuberculous in sanatoriums, usually located in country districts, increased, more deaths were artificially credited to rural places. Census Bureau definitions of "rural," moreover, have been changed as has the accuracy of death reporting in country districts. Despite these limitations, certain general trends in the tuberculosis death rate, as between cities and rural districts, are evident.

Rural and Urban Tuberculosis Death Rates

While tuberculosis mortality has been declining in urban and rural sections alike, it is probable that the rate of decline in the cities has been greater than in the country. In 1890, when hospital deaths were too few to influence the rural-urban comparisons substantially, the death rate for pulmonary tuberculosis in the cities of registration states was 62 per cent higher than the rate in the rural parts of these states. The differential fell to a total urban rate (49.4 per 100,000) only about 20 per cent higher than rural rate (41.3 per 100,000) in 1940.

Accurate urban and rural tuberculosis death rates cannot be determined for any year since 1940. It is estimated, however, that the approximate urban tuberculosis death rate in 1946 was 38.7 per 100,000 and the rural rate 34.9. These figures represent a further decline of the urban rate at a more rapid pace than that of the rural rate.

Even in 1940, the rural tuberculosis death rate was higher than the urban in certain demo-

graphic groups. The rural death rate for white females is actually higher than the urban at all ages from 15 years up. Among nonwhite females, the rural death rate exceeded the urban at ages above 54 years. Among males the rural death rate exceeded the urban in the highest age groups.

These findings illustrate what happens to the tuberculosis death rate in sex-age groups least subject to frequent epidemiologic contacts. Of the various groups, white women have the least contact with the general population. Among aged persons, contact is also likely to be minimal. In other words, among groups with the fewest epidemiologic contacts, the rural death rate from tuberculosis is already higher than the urban. Case finding and isolation of active cases from a community reduce epidemiologic contacts. As these steps are taken in the cities, we may expect the curves for urban and rural tuberculosis death rates ultimately to cross, with urban rates becoming lower than rural for all age-sex-racial groups.

Rural Life and Tuberculosis

Controlling tuberculosis in rural America is made difficult by the same factors that impede the provision of general public health and medical services. Low per-capita income and low population density, with concomitant deficiencies of medical personnel, facilities, and health agencies, create handicaps in the battle against tuberculosis as against most diseases.

The central fact that characterizes the approximately 55,000,000 Americans living in rural areas, as compared with city-dwellers, is lower

average family incomes. Citation of only the most obvious of the elements entering into a standard of living—education, housing, nutrition and the use of labor-saving devices—reveals the basic distinction at rural and urban levels. Rural educational levels, including education on personal hygiene and living habits, are woefully below the urban. It may not be so widely recognized, but the Census Bureau figures show that average rural housing is actually more congested than urban. Rural families are larger than urban and acres of land around a home do not add space to the rooms in which the family eats, sleeps, and lives.

The relevance of this to the problem of tuberculosis would seem to be this: if tuberculosis is the classical "social disease" the socio-environmental factors contributing to its occurrence are, with one important exception, epidemiologic contacts, found most strikingly today in rural parts of the United States. Except for the increased opportunity for the person-to-person spread of tubercle bacilli in the cities, the conditions of rural life in America today provide the basis for a higher tuberculosis mortality than do those of urban life.

Measures for Urban and Rural Tuberculosis Control

The measures for reducing epidemiologic contact with unrecognized cases of tuberculosis which are being employed in urban areas are case finding through private physicians, public health tuberculosis clinics, and mass X-ray surveys, and isolation of cases through hospitalization. There are special handicaps to all these measures in rural America. Yet if rural tuberculosis is to be reduced, comparable measures of control are necessary.

The Rural Challenge

As living conditions improve, the effective case finding, treatment, and isolation of patients reduces the prevalence of tuberculosis in the cities, the task of final eradication of the disease in the rural areas must be faced. Present trends point to the time when tuberculosis may become the predominantly rural problem that typhoid fever, once an urban scourge, has become today.

The lesser epidemiologic contacts of country-dwellers is a distinct advantage in fighting the disease. While it may be harder to find cases among rural people and harder to get them isolated and treated, the channels of person-to-person spread are fewer.

The attack on rural tuberculosis cannot be ef-

IF YOU CAN'T STOP AND LOOK, THEN LISTEN!

"He's an awfully good Doctor, but I can't talk to him." How often have you heard a patient make that remark about a fellow practitioner? Or are you one of the accused who won't listen long enough to avoid being placed in the same category? It is not the usual function of this department to "editorialize," but when one hears the above accusation over and over again, it becomes apparent it is everyone's business to do something about it.

One of the unfortunate things about the practice of Medicine is that the longer we practice it, the more likely we are to lose perspective. With the passage of years it becomes increasingly difficult to follow the lay viewpoint, and yet upon that very viewpoint lies the destiny of Medicine today. It isn't what YOU think that will determine whether or not we shall have socialized Medicine, but what the layman, your patient, thinks that will determine the issue.

From all accounts, we, as a profession, are pretty well satisfied with things as they are. Oh, sure, we admit that a few changes might be desirable; that more and better professionally sponsored health plans may be necessary; that rural areas are somewhat neglected under the present set-up. But we seem to lose sight of the fact that the very forces threatening to destroy our professional integrity were engineered not by other physicians, but by the very laymen who are our actual or potential patients. Which means, of course, that the public at large not only fails

effective unless it is launched on all fronts of rural health service. Rural housing, education, nutrition, and general living standards must be elevated. The services of competent physicians must be available for the everyday care and prevention of illness and hospital services must be expanded as needed. Public health agencies must be extended and X-ray services for periodic chest check-ups must be made accessible. Social measures for the families of persons disabled with tuberculosis must be provided.

Unless these steps are taken, we may expect a permanent reservoir of tuberculosis to smolder indefinitely in rural districts. With these steps taken in city and country alike, tuberculosis can be eradicated from America.

Tuberculosis and Its Control in Rural Areas, Milton I. Roemer, M.D., M.P.H., Public Health Reports, October 7, 1949.

to share our complacency, but proposes to do something about it.

The subject matter is far too broad to be encompassed in a few pointed paragraphs, but the fundamentals may be emphasized in less space than that. When we fail to recognize, or cease to care, what the laity thinks about us as a profession; when we are so busy being Doctors that we fail on the side of human relationships; when we become so thoroughly steeped in the scientific aspects of Medicine that our patients become case-numbers instead of individuals, we are deliberately opening the door to outside intervention. And this observer isn't at all sure we won't deserve it.

When a physician tells us he "sees" fifty patients in an afternoon, we are quite willing to believe him. He "sees" them, all right, but that is about all he does. If he means that fifty patients came into his office and better than half of them were "treated" by an office attendant, it lends further credence to his claim. The Doctor may stick his head into a treatment room and say "Hello," but he doesn't dare add, "How are you?" as that would call for a reply. And he simply hasn't time for a reply if he is to "see" his daily quota.

Well, then, how did he get the reputation for being "an awfully good doctor" in the first place? And why do patients continue to come to this man they "can't talk to"? The answer is simpler than it seems. He established his reputation BEFORE he became too busy to talk to, and has more or less maintained it through his very appearance of success. Also, the law of averages gets in its good work at this point, what with a high percentage of ailments being self-limited, and thus easily "curable," and the volume of business being so great he doesn't miss the frequent backslider who quits the fold for a physician he CAN talk to.

Of course, this more-approachable man may be building up for the big league, himself, and ultimately falls into the same fifty-by-nightfall group, thus making the patient unhappy, disgruntled and quite ready to vote for anything that promises to "change this sorry scheme of things entirely." He argues he can't possibly do worse under any plan whatsoever. All of which, however unpleasant the reading, may cause us to remember that:

If you can't stop and look, then listen!

J. Phil. Edmundson, M. D., in Jackson County (Mo.) Medical Society Bulletin.

PERSONALS AND NEWS ITEMS

Earl Parsons, Jr., has moved to new offices at 814 West Third Street, Little Rock.

Louis A. Cohen has moved to new offices at 814 West Third Street, Little Rock.

Diagnostic cancer clinics under the sponsorship of the county medical society and the Arkansas Cancer Society were conducted at Eureka Springs March 31st by S. W. Hawkins and W. R. Brooksher, Fort Smith, and at Booneville, March 29th, by D. W. Goldstein, R. G. Kramer and W. R. Brooksher, Fort Smith.

A. B. Dickey, State Sanatorium, recently addressed the south Logan county council on home demonstration clubs on "Health Problems."

BORN—On April 4th, Charles Reid Henry, Jr., to Dr. and Mrs. Chas. R. Henry, Little Rock.

A diagnostic cancer clinic under the sponsorship of the county medical society and the Arkansas Cancer Society was conducted at Paris April 5th by D. W. Goldstein, A. S. Koenig, Robert Thompson and J. D. Olson, of Fort Smith.

R. B. Robins, Camden, made addresses during April as follows: Jefferson County Auxiliary "Doctor's Day" program, Pine Bluff; Tennessee State Medical Association, Memphis, and Delta Medical Society, Rosedale, Mississippi.

"A Layman's Faith" by R. E. Crigler, Fort Smith, appeared in Arkansas Methodist recently.

M. J. Kilbury, Little Rock, attended the Central Regional meeting of the College of American Pathologists and the Saint Louis Pathological Society at Saint Louis March 25th and 26th.

Daniel H. Autry has moved to new offices at 1442 Donaghey Building, Little Rock.

"The Importance of Medical Economics" by R. B. Robins, Camden, appears in the first issue of "G P."

W. M. Hamilton has opened offices for the practice of internal medicine at 1442 Donaghey Building, Little Rock.

Roy E. Schirmer, Fort Smith; Allan G. Cazort

and Ellis P. Cope, Little Rock, attended the Southwest Allergy Forum at Memphis, April 2nd, 3rd and 4th.

J. T. Herron, Little Rock, has been elected a Fellow of the American Board of Preventive Medicine and Public Health.

The recent obstetrics postgraduate study course at the University of Arkansas School of Medicine was attended by: H. L. Brown, Malvern; O. D. Butterick, Elaine; G. G. Hairston, Prescott; Rowlan Hawkins, McGehee; James D. Huskins, Siloam Springs; W. G. Klugh, Hot Springs National Park; Byron Futrell, Rector; F. C. Maguire, Augusta; J. H. Miller, Camden; J. O. Porter, Morrilton; W. S. Rainwater, Hampton; John W. Redman, Fort Smith; Paul Sizemore, Magnolia; Paul H. Woods, Hot Springs National Park, and F. Q. Wyatt, Batesville.

Gilbert Dean, Little Rock, attended the American Association for Thoracic Surgery and the American Surgical Association meetings during April.

Robert Watson, Little Rock, attended the meeting of the Harvey Cushing Society at Colorado Springs during April.

The Section of Ophthalmology and Otolaryngology recently elected the following officers for 1950-1951: Chairman, Paul L. Mahoney, Little Rock; Vice-Chairman, C. G. Hinkle, Batesville; Secretary-Treasurer, K. W. Cosgrove, Little Rock; Delegate, John W. Smith, Little Rock, and Alternate, L. Gardner, Russellville.

Chas. R. Henry and Robert W. Ross have moved into new offices at 1305 Donaghey Building, Little Rock.

Ellery C. Gay, Little Rock, has been appointed Colonel, Medical Corps Reserve, and assigned to the Office of the Surgeon General as plastic surgeon.

J. H. Pinson, Jr., El Dorado, has been elected surgeon of the El Dorado post, Veterans of Foreign Wars.

Howard Schwander has opened offices at 939 Donaghey Building, Little Rock.

S. W. Douglas, Eudora, was honor guest at

WOMAN'S AUXILIARY NEWS

The doctors of Howard-Pike County Medical Society were honored on Doctors' Day at a dinner at "Lana Tea Room."

The Auxiliary gave a Benefit Bridge and Canasta party on March 31 to raise money to buy shrubs for the grounds of the Howard County Memorial Hospital.

Mrs. H. H. Holt.

Mrs. L. K. Hundley of Pine Bluff, president of the Arkansas Medical Auxiliary, was honor guest at a luncheon given at Brinkley by Mrs. E. D. McKnight for the Monroe County Medical Auxiliary on April 6. Mrs. Hundley spoke on "Our Freedom."

Mrs. McKnight was elected president of the group for 1950-51. Mrs. P. E. Terry of Holly Grove was named vice-president, and Mrs. M. L. Dalton of Brinkley, secretary-treasurer. Mrs. E. A. McCracken of Cotton Plant, a member-at-large, was named reporter.

The County Auxiliary voted to meet every two months, on the first Wednesday. Mrs. Dalton will be hostess at the next meeting, to be held June 7 at 2:15 P. M.

Other members present were Mrs. L. H. Stout, Mrs. J. P. Williams, Brinkley; Mrs. Herd E. Stone, Holly Grove, and Mrs. Ben Pupsta, Clarendon.

The Auxiliary to the Greene-Clay County Medical Society met April 12 in Paragould at Dr. and Mrs. R. J. Haley's farm, "Pinecrest."

The Auxiliary in observance of Doctor's Day honored the twenty-one doctors and four guests with a dinner. Guests for the evening were Dr. and Mrs. Paul Stroud and Dr. and Mrs. Joe Led-

Doctor's Day celebration held by the Woman's Auxiliary to the Southeast Arkansas Medical Society in Pine Bluff March 30th.

"Some Surgical and Technical Aspects in the Usage of Wire Sutures" by Gilbert O. Dean, Little Rock, appeared in the Southern Surgeon, March issue.

BORN—A son, Stephen Frank, March 26th, to Dr. and Mrs. R. G. Kramer, Fort Smith.

Pearl Waddell, Fort Smith, and Vida Gordon, Little Rock, attended the recent regional meeting of the American Academy of Pediatrics at Philadelphia.

better of Jonesboro. Dr. Stroud spoke to the doctors on "Caudal Anesthesia."

The Auxiliary voted to put one year's subscription to "Hygeia" in the High School Library.

The ladies of the Auxiliary meet once a week in the linen room of the Community Methodist Hospital and mend and make linens for the new hospital.

New officers for 1950 are as follows: President, Mrs. A. D. Garner, Paragould; Vice-president, Mrs. R. C. Jones, Piggott; Secretary, Mrs. Alfred Maddox, Paragould; Treasurer, Mrs. Earl McKelvey, Paragould.

Doctor's Day was observed Thursday evening at Oakland Club, featured by a buffet supper. Physicians and their wives from Pine Bluff and southeast Arkansas were joined by men and women in professions related to medicine, in observance of the occasion.

Dr. R. B. Robins, of Camden, guest speaker, spoke on "The Months Ahead." He said the "doctors, druggists, dentists, nurses, hospital people, their wives, relatives, and all other friends must exercise their rights as citizens in order to defend their professional and civil freedom in America today." He urged his audience to take active part in political elections and work for candidates whose views "reflect the principles we believe are of fundamental importance to the preservation of the American way of life." Dr. Robins was introduced by Mrs. Louis K. Hundley.

Also sharing honors was Dr. S. W. Douglas of Eudora, Arkansas, who will soon reach his four-score years, and is said to be the oldest physician in southeast Arkansas. He was active in his profession until four years ago when failing eyesight forced his retirement.

The doctors present wore the official Doctor's Day flower, a red carnation boutonniere. The speakers' table was centered with an arrangement of red carnations and spring flowers were used on the serving table and down the center of the dining tables. Mrs. Allen R. Russell was in charge of the decorations.

Greeting guests at the door were Mrs. Howard S. Stern, president of the Auxiliary to the Jefferson County Medical Society; and Mrs. Clyde Hart, Jr., Program Chairman, and Mrs. Hunter A. Causey. Serving at the buffet were Mrs. Harold J. Morris, Doctor's Day Chairman;

Mrs. James T. Rhyne, Mrs. Charles W. Anderson and Mrs. Charles W. Reid.

The Woman's Auxiliary to the Union County Medical Society entertained their husbands with a Doctor's Day dinner March 24 at the Country Club. There were 23 doctors and their wives present.

The dinner was preceded by a social hour. Decorations were in the Easter motif.

Hostesses for the occasion were: Mrs. Frank Clark, Mrs. Gardner Landers and Mrs. Jack Sheppard. The committee in charge of decorations were: Mrs. Warren Riley and Mrs. Garland Murphy, Jr.

The Garland County Medical Auxiliary met for its regular monthly meeting Monday, March 20. The occasion was a coffee at the home of Mrs. L. E. Reed with Mrs. W. E. Gray, Mrs. Paul Woods and Mrs. Cecil Parkerson as co-hostesses.

Mrs. Leeman King, president, presided over the business meeting. The following were elected as new officers for the coming year:

Mrs. John Dodson, President; Mrs. Robert Adkinson, President-elect; Mrs. Cecil Parkerson, 1st Vice-president; Mrs. James Leatherman, 2nd Vice-president; Mrs. Lauren Bohnen, 3rd Vice-president; Mrs. E. K. Clardy, Secretary; Mrs. Jack Wright, Treasurer; Mrs. W. Turner Wootton, Historian; Mrs. George Fletcher, Poet Laureate.

Announcement was made of the twenty-sixth annual meeting of the Auxiliary to the Arkansas Medical Society at Fort Smith April 17-19. Mrs. Frank Adams and Mrs. H. King Wade, Jr., were elected delegates with Mrs. Charles Lutterloh and Mrs. Euclid Smith alternates.

Doctor's Day will be observed March 30.

Mrs. L. E. Reed, Publicity Chairman.

The Woman's Auxiliary to the Pulaski County Medical Society met on March 15th at 12:00 noon for a luncheon at the Junior League House. The president, Mrs. J. Harry Hayes, presided over the business meeting. The following officers for the coming year were elected:

President, Mrs. T. D. Brown; President-elect, Mrs. Gordon P. Oates; 1st Vice-president, Mrs. J. Harry Hayes; 2nd Vice-president, Mrs. Ben Means; Secretary, Mrs. E. L. Wilbur; Treasurer, Mrs. Paul Fulmer; Corresponding Secretary, Mrs.

James Newbill; Historian, Mrs. N. T. Hollis; Parliamentarian, Mrs. Mason G. Lawson; Publicity Secretary, Mrs. Alfred Kahn, Jr.

Delegates elected to the State Convention are: Mrs. Ben Means, Mrs. T. D. Brown, Mrs. Dan Autry, Mrs. Raymond Cook, Mrs. Edwin Gray, Mrs. W. G. Cooper and Mrs. Erner Jones. Alternates are: Mrs. J. B. Crawford, Mrs. Frank Kumpuris, Mrs. Hoyt Choate, Mrs. Paul Fulmer, Mrs. Leo Aday, Mrs. James Headstream and Mrs. Fred Harris.

Mrs. Vernon Newman and Mrs. Doyle Fulmer, chairmen of the Cancer Control Committee, were program chairmen for the day. They presented Dr. Harry Hayes as speaker of the day, who talked on "The Prevention and Cure of Cancer." They also presented the Commander of Pulaski County Cancer Society, Mrs. Gordon P. Oates, who showed a cancer film, entitled "A Question in Time." The Executive Secretary of the Pulaski County Cancer Society, Mrs. Margie Bartlett, was a guest of the Auxiliary. Another member of the Cancer Society, Mrs. Robert Thompson, Child Education Chairman, was also present.

Hostesses for the day were: Mrs. Estes Allen, Chairman, and Mrs. Mahlon D. Prickett, Mrs. John Wassell, Mrs. Harlan Hill, Mrs. T. Duel Brown and Mrs. James Newbill.

The Auxiliary was honored by a visit of the Pulaski County Medical Society's President, Dr. Dan Autry, who gave a short talk.

March 30th, Doctor's Day, was celebrated with a gingham and galluses party, square dance and all. Mrs. Ralph McLochlin was Chairman of the Auxiliary activities for Doctor's Day.

Pulaski County Medical Auxiliary met on February 15th at the Junior League House. The hostesses for the meeting were: Mrs. J. B. Crawford, chairman; Mrs. W. D. Sessoms, Mrs. A. H. Sparks, Mrs. C. M. Brooks, Mrs. N. T. Hollis and Mrs. R. W. Beck.

Program for the day entitled, "The Doctor's Wife and the Doctor's Secretary," was in the plan of a forum with the following participants: Mrs. Ben Means, Mrs. W. J. Cooper, doctor's wives; Mrs. Marguerite Broderick, secretary to Dr. Charles Henry, and Mrs. Elza Lee Dunn, secretary to Dr. Marion Craig.

Plans are being made for a children's style

show to be given in March, benefit of the Student Loan Fund.

Mrs. Gordon P. Oates,
Publicity Chairman.

The Woman's Auxiliary to the Pulaski County Medical Society will meet on April 29th at 12:00 noon at the Junior League House for a business luncheon. Mrs. J. Harry Hayes will preside over the business session.

Governor McMath of Arkansas will be guest speaker of the day. Hostesses for this meeting are: Mrs. Carl Rosenbaum, Chairman, and Mrs. Alfred Kahn, Jr., Mrs. Dale Alford, Mrs. Hoyt Choate, Mrs. Forrest Henry, Jr., and Mrs. Paul Hoover.

Report of the Children's Style Show for the benefit of the Student Loan Fund, which was given on March 21st, will be presented by the Chairman, Mrs. Gordon P. Oates. Also report on Doctor's Day activities will be given by the Chairman, Mrs. Ralph McLochlin. Reports from the State Convention will be heard at this time also.

Mrs. Gordon P. Oates,
Publicity Chairman.

BOOK REVIEW

The Eye and Its Diseases—by 92 International Authorities: Edited by Conrad Berens, M.D., F.A.C.S. New, 2nd edition. 1,092 pages with 436 figures, 8 in colors. Philadelphia and London: W. B. Saunders Company, 1949. Price \$16.00.

The thirteen years since the publication of the first edition of this book in 1936 have seen considerable progress in the field of ophthalmology. In this new edition practically all the contributors have rewritten their chapters and many new chapters have been added. Recent advances in therapeutics, the field of antibiotics and other new drugs and their use in ophthalmology have been well covered. Less space is devoted to some subjects such as trachoma, whose relative importance has decreased. The new chapters include discussions on illumination, the physiological chemistry of the eye, and gonioscopy. Like the original edition, this new book is the only comprehensive text book of ophthalmology under one cover. It serves as an excellent reference for the student and practitioner of ophthalmology and holds also much of interest to the general practitioner. Certain details not seen in this edition would be readily available through study of the excellent bibliographies following each chapter.

Mitchell-Nelson's Textbook of Pediatrics: Edited by Waldo E. Nelson, M.D., Professor of Pediatrics, Temple University School of Medicine; Medical Director, Saint Christopher's Hospital for Children, Philadelphia. With the collaboration of sixty-three contributors. New, 5th edition. 1,658 pages with 426 illustrations, 19 in color.

Philadelphia and London: W. B. Saunders Company, 1950. Price \$12.50.

Griffith-Mitchell has long been accepted as an outstanding textbook in Pediatrics. Dr. Nelson, who worked with Dr. Mitchell on the fourth edition, has done a notable piece of work on this volume. There are sixty-three (63) collaborators, all of acknowledged standing in their particular field. The book has been enlarged and brought up to date. Many chapters have been rewritten to include data of recent origin and a number of new chapters have been added. There is no other single volume on pediatrics that covers the field as adequately and in such detail. Both the medical student and the practitioner will find it of material value. It should serve an indispensable purpose in the library of every individual doing either general practice or pediatrics.

Outwitting Your Years. By Clarence W. Lieb. New York: Prentice-Hall, Inc., Price \$2.75.

This is a book written for the laity with emphasis on the physical, mental and spiritual difficulties which afflict the individual past the age of fifty. It is written with sympathetic understanding and will serve its purpose well.

Blakiston's New Gould Medical Dictionary. First Edition. Edited by Harold W. Jones, M.D., Colonel, U. S. Army; Normand L. Hoerr, M.D., Professor of Anatomy, School of Medicine, Western Reserve University; Arthur Osol, Ph.D., Professor of Chemistry, Philadelphia College of Pharmacy and Science. 1,294 pages with 252 illustrations, 129 in color. Philadelphia: The Blakiston Company, 1949. Price \$8.50 textbook edition; \$10.75 thin paper edition, and \$13.50 deluxe edition.

This dictionary represents an effort to present the intricacies of an ever-expanding medical vocabulary in new pattern, deleting obsolete and irrelevant material. Self-pronunciation with the use of phonetic spelling is used throughout. An excellent arrangement is the grouping of plates in the center of the book and of reference tables at the back. This is a valuable new type of dictionary.

QUESTIONS Medical State Board and ANSWERS: By R. Max Goepp, M.D., Formerly Professor of Clinical Medicine, Graduate School of the University of Pennsylvania, and Professor of Medicine, Woman's Medical College of Pennsylvania; and Harrison F. Flippin, M.D., Associate Professor of Medicine at the Graduate School of the University of Pennsylvania. New, 8th Edition. 663 pages. Philadelphia & London: W. B. Saunders Company, 1950. Price \$7.00.

This is a well-known and popular text. The present edition has been rewritten throughout with attention to newer advances in the field of the medical sciences and will serve, as it has, for review in preparing for various medical examinations.

Normal Values in Clinical Medicine: By F. William Sunderman, M.D., Ph.D., Professor of Experimental Medicine and Clinical Pathology, University Texas Postgraduate School of Medicine; and Frederick Boerner, V.M.D., Late Associate Professor of Clinical Bacteriology, Graduate School of Medicine, University of Pennsylvania. 845 pages with 237 figures and 413 tables. Philadelphia and London: W. B. Saunders Company, 1949. Price \$14.00.

In this volume effort has been made to compile a reference book on normal values in medicine and it is

arranged by body systems and also by some of the specialties. Forty-four collaborators served in the preparation of the book and its usefulness will be generally appreciated.

Essentials of Obstetrical and Gynecological Pathology.

Robert F. Faulkner, M.D., F.A.C.S., Asst. Prof. of Gynecology, Western Reserve Medical School and Marvin Douglass, M.D., Formerly Asst. Prof. of Gynecology, Western Reserve Medical School, 2nd Edition. Price \$8.75. St. Louis: C. V. Mosby Co., 1949.

This book is designed to teach the essentials of obstetrics and gynecologic pathology to those who have not had the advantage of specialized pathologic training. Physicians engaged in the practice of obstetrics and gynecology will find this book a valuable adjunct in making diagnoses and decisions upon which the patient's welfare is so dependent.

The female genital tract is presented basically in the order that one does a pelvic examination, starting with the vulva and progressing to include the vagina, cervix, uterus, tubes, and ovaries. The book ends with a comprehensive chapter on the pathology of pregnancy. The illustrations being numerous and clearly described are a dominant feature. There are 357 pages in this book with 300 illustrations including three color photos.

This book is a valuable addition to the library of any physician engaging in the practice of obstetrics and gynecology.

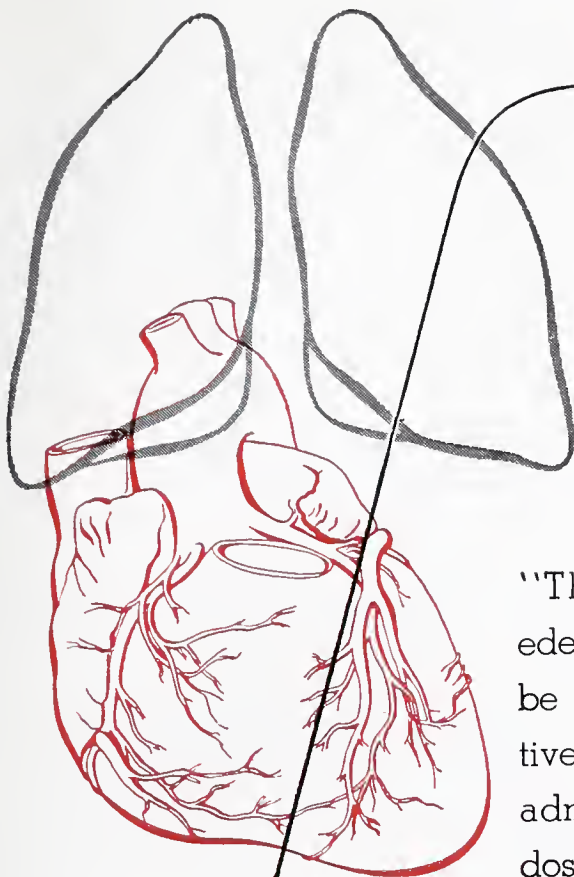
Clinical Pathology—Application and Interpretation: By

Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, University of Arkansas School of Medicine, Little Rock, Arkansas. 397 pages with 32 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price \$6.00.

Here is a book which should be part of the library of every physician practicing clinical medicine, either surgeon or internist. It has been written by a clinical pathologist for the clinician.

With the multiplicity of the technical procedures which have been devised for the diagnosis of diseases, the clinician is often at a loss as to which test to select for a particular purpose, and after the test has been selected frequently he is unable to interpret the results in the light of a clinical problem. The clinical pathologist is often asked, for instance, "What is the best test of liver function?" The answer, as it applies to liver disease as well as to tests for other functional activities, is: "The best test for which purpose?" Some clinical laboratory procedures are used rather widely, but may have little significance and contribute but a small amount of information toward the solution of the problem at hand. In Dr. Wells' book he presents the various problems which confront the clinician and then discusses the pertinent laboratory procedures and their interpretation in the particular condition. In this manner there are nine chapters which deal in the application of clinical pathologic methods, to infectious diseases, diseases of the intestinal system, diseases of the respiratory system, the kidney and urinary tract, diseases of the blood, the cardiovascular system, and metabolic and endocrine disorders. The eighth chapter deals with clinical laboratory studies in surgery and the ninth on clinical laboratory studies in obstetrics.

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1. Barach, A. L.: Edema of the Lungs, Am. Pract. 3:27 (Sept.) 1948.

at least three things about every laboratory procedure he expects to use: 1. When to use it. 2. How to interpret the results. 3. What technical or physiologic limitations must be taken into account in the interpretation. The text is devoted to the answers of these three questions. Dr. Wells indicates which laboratory procedures are useful and which contribute little information. The text is very readable and contains considerable information. The University of Arkansas is fortunate to have such a well informed person as Dr. Wells as a member of their faculty, and his book adds much to clarify many of the complexities of clinical pathology in their relationship to clinical medicine.

The Cytologic Diagnosis of Cancer: By the Staff of the Vincent Memorial Laboratory of the Vincent Memorial Hospital. A Gynecologic Service Affiliated with the Massachusetts General Hospital, Boston, Massachusetts. The Department of Gynecology Harvard Medical School. Published under the sponsorship of The American Cancer Society. 229 pages with 153 figures. Philadelphia & London. W. B. Saunders Company, 1950. Price \$6.50.

This very excellent manual which has been prepared by the technician staff of the Vincent Memorial Laboratory is, as is stated in the preface, essentially a laboratory manual. The book begins with a discussion of the normal and abnormal physiology of the female genital tract. Subsequent chapters discuss cytological diagnosis on material from the respiratory tract, stomach, urinary tract and pleural and peritoneal fluids. At the beginning of each chapter there is a histologic section of the tissue under discussion as a point of orientation. This is followed by a black and white photomicrograph and colored drawing of a field of classical desquamated cells derived from that epithelium. In this respect the manual provides for what the interviewer considers inadequacies in the monographs of Papanicolaou and Trout, and Gates and Warren. In the former the illustrations are exclusively drawings, while in the latter the illustrations are principally black and white photomicrographs. In the present manual of the Vincent Laboratory group the student of cytology is presented with the actual photograph of the material, while the drawings of the same fields supplement and augment the interpretation of the observed cells. In each instance the text gives a clear, concise description of the various types of cells, pointing out the salient features and characteristic appearances which are important in cytological interpretations.

At the beginning of the discussion of the cells in the various portions of the body there is a complete and thorough description of the normal cytology before presentation of the various malignancies affecting the areas. This book fulfills a need which has long existed since the widespread adaptation of the cytological technique in the diagnosis of malignancies. In general the technical methods, which are thoroughly discussed in the last chapter, follow those devised by Dr. Papanicolaou and his associates at Cornell. The book should be an essential part of the library of any laboratory which does cytological work.

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JUAN DEL REGATO, M. D., Colorado Springs

SCHEDULE

MEETING BEGINS	3:00 P. M.
SOCIAL HOUR	6:00 P. M.
DINNER FOR DOCTORS AND WIVES	7:00 P. M.

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